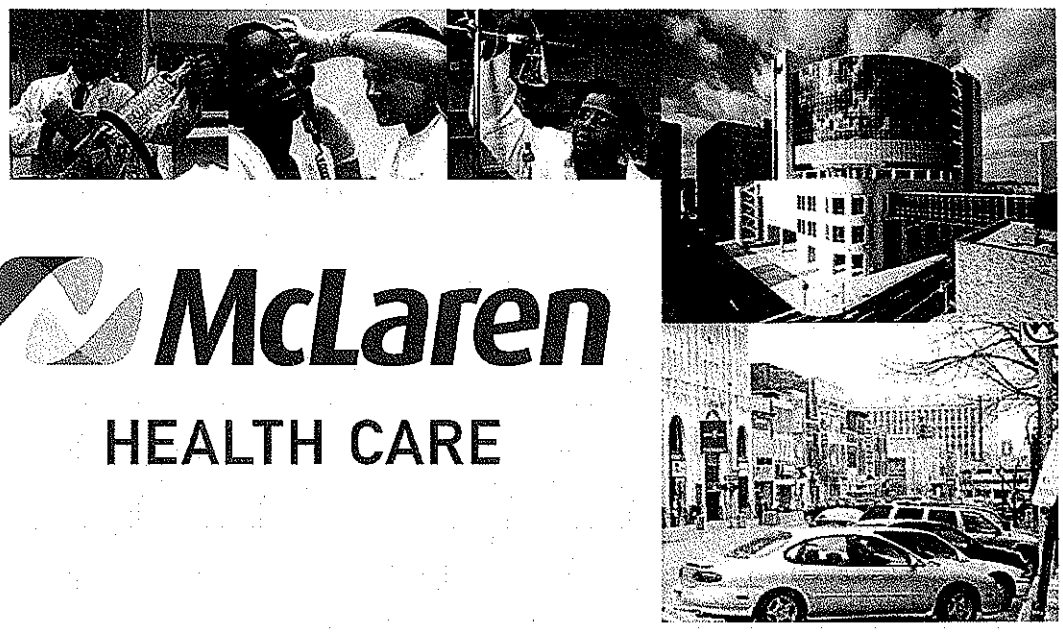


McLaren
HEALTH CARE

McLaren Health Care

Improving Accessibility to High Quality, Cost Effective Health Care

In Pontiac and Northern Oakland County

McLaren Health Care

Improving Accessibility to High Quality, Cost Effective Health Care

In Pontiac and Northern Oakland County

Executive Summary

As a matter of business, McLaren Health Care routinely addresses the issues of balancing access to high quality health care in a cost effective manner while remaining mindful of our responsibilities to the communities we serve. We are proud that we provide access for the physical health and well being of the people we care for; and we are a major contributor to the economic health of the community as well. We believe that as a good corporate citizen, we must develop and execute comprehensive plans that ensure that our services are the best they can be, that they reflect the needs of the community today, as well as into the future and contribute to the economic stability and growth of the community.

The health care environment changes every year. These changes come to us through advances in technology, medicine, the economy, reimbursement and regulation. Health care is something we all care about and providers like McLaren are looked to for answers. In addition we serve as a major employer (one of the top 10 largest in Michigan) and our resources are depended upon for the financial viability of the areas in which we serve our patients. McLaren understands this responsibility and our strategic plan includes economic investment in the regions where we provide care.

INVESTMENT IN PONTIAC

McLaren Health Care believes a key element for success is our investment in the future of the communities we serve. This commitment allows our subsidiaries to grow and remain strong, thereby strengthening our entire organization. This is the primary reason that McLaren - Oakland (formerly POH Regional Medical Center) became a member of McLaren Health Care. Absent McLaren Health Care, the burden of uncompensated care in Pontiac would have become overwhelming for this facility and a valuable safety net asset of the community would likely have been lost.

As a result of the acquisition in 2007, McLaren has taken the following steps to reformat its pledge to Pontiac. Our commitment is based on providing the health care services that patients need and are essential to strengthen both McLaren - Oakland as a provider and McLaren Health Care as a system. There are three key components of our vision for the Pontiac community:

I. Building a sustainable healthcare delivery model for the city of Pontiac
II. Developing a platform for education, job training, housing, collateral development
III. Strategically plan for the McLaren – Clarkston campus

I. BUILDING A SUSTAINABLE HEALTH CARE DELIVERY MODEL FOR THE CITY OF PONTIAC

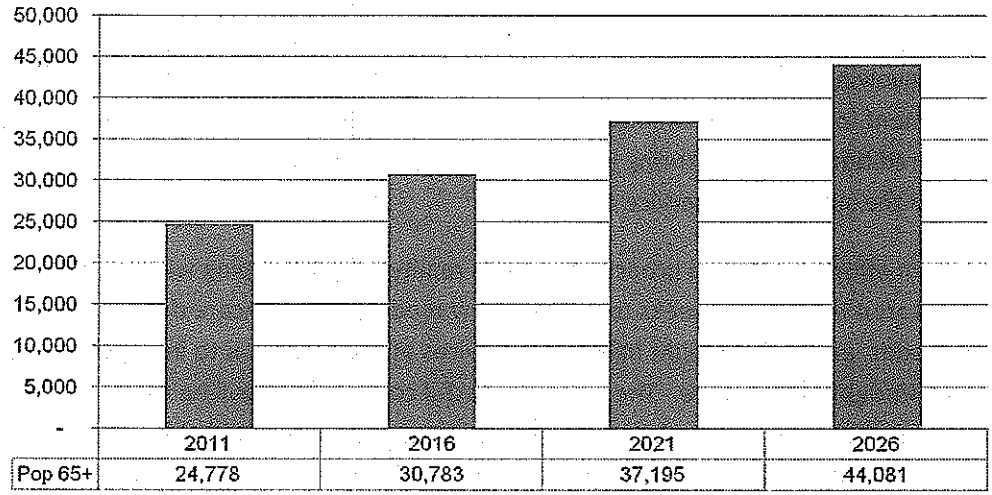
Pontiac, along with other older industrial regions throughout Michigan, is faced with rapidly changing health and social services needs. These changes are due to advancements in medical technology, and constantly evolving public policy decisions combined with ongoing reductions in federal and state reimbursement for Medicare, Medicaid and Welfare programs. To further complicate matters, the decline in traditional manufacturing jobs has also contributed to significant economic challenges in Pontiac and the surrounding service area.

As part of an effort to respond proactively to this reality, and in keeping with our mission, vision and values, McLaren Health Care seeks to develop new models of healthcare delivery that build healthier neighborhoods, and find the right balance of services at each location to increase access to high quality, safe and affordable health care. The most successful communities will be those in which the stakeholders work collaboratively to define the blueprint for sustainable health and wellness services and the associated economic development those initiatives can bring to the community.

The Pontiac and Clarkston campuses of McLaren - Oakland are an example of this model for McLaren Health Care. McLaren will link its investments in a manner that will maintain high-paying health care jobs in downtown Pontiac. We will also create new jobs in health care delivery and health education through a partnership with local colleges, universities and school districts. McLaren Health Care has spent the last two years researching and studying this opportunity and is now in a position to implement a 3 point plan:

1. **Population-based bed distribution**
   Dramatic shifts in population have occurred over the last three decades in the Pontiac and northern Oakland County market. Between 1970 and 2010, the City of Pontiac population decreased 30% from 85,279 to 59,515 (2010 U.S. Census). During this timeframe, the population of Independence Township has increased over 100%. Further, the growth of the seniors (65+) in the Clarkston service is expected to increase approximately 25%. A significant consideration as they consume health care resources at a much higher rate than all other population age segments.

Clarkston Service Area Population Growth – Seniors



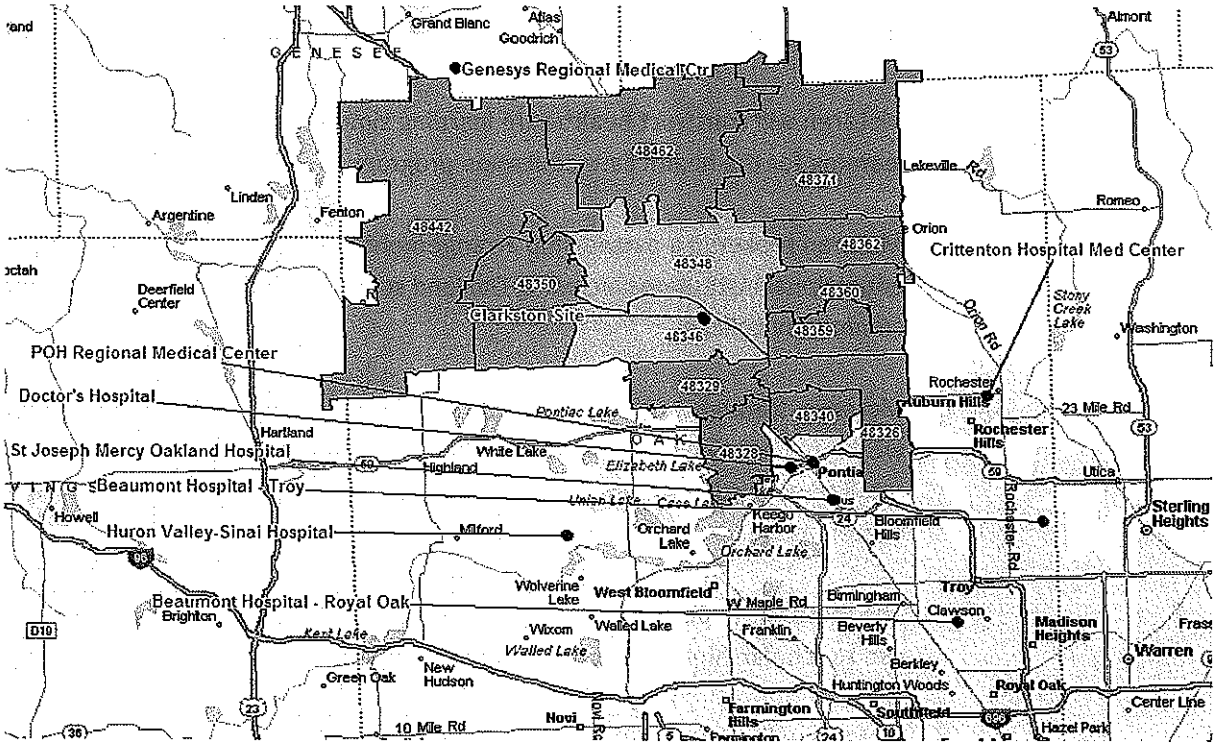
Change:	2011-2016	2016-2021	2021-2026
USA	15.9%	14.2%	13.2%
Michigan	12.1%	11.2%	10.7%
Oakland & Surrounding Counties	12.3%	12.1%	11.1%
Clarkston Service Area	24.2%	20.8%	18.5%

Source: Thomson Reuters

These dramatic shifts in population demand a geographically appropriate, market based redistribution of licensed acute care beds. McLaren - Oakland maintains 308 licensed acute care hospital beds and 20 psychiatric beds at its downtown Pontiac site. The facility has recently received approval to add an additional 7 psych beds, bringing the total bed count to 335. This site typically maintains an average census of 97 admitted patients. McLaren proposes to retain 108 licensed acute care beds and the 27 psychiatric beds for a total of 135 beds at that location resulting in an average occupancy of 90%. Additionally the Pontiac hospital will continue inpatient and outpatient medical and surgical services, and remain a Level II trauma care provider.

As part of this restructuring, McLaren - Oakland will relocate 200 beds of the 335 beds to its Clarkston site. A 2011 Thompson Reuters bed-need study demonstrated that the Pontiac market will require 385 licensed beds to meet market demand in 2015. Currently there are 1,024 licensed beds serving the Pontiac market – an oversupply of 639. The same study also projected a need for 161 beds in the Clarkston market by 2015. McLaren - Oakland can meet this demand and maintain at least 80% occupancy in Clarkston while doing its part to remove 200 beds from Pontiac. McLaren - Oakland can maximize efficiency, while not increasing the overall bed inventory in Oakland County.

McLaren Clarkston Service Area



Source: 2011 Thomson Reuters

2. Investment and Service Expansion in Pontiac

During 2012, McLaren - Oakland will make capital investments to support the growth and expansion of key health care services at the Pontiac Campus including, but not limited to, a nearly $9,000,000 investment in program enhancement for Cardiovascular services, surgery, endoscopy, geriatric psychiatry, trauma, and infrastructure.

3. Primary Care Capacity Expansion

Access to basic primary care services is the cornerstone of a healthy community. McLaren - Oakland will continue to expand the primary care medicine base in the city of Pontiac by increasing the number of Family Practice physicians serving the market including increasing the size of the current Federally Qualified Health Center. McLaren - Oakland will be able to provide comprehensive services to both Pontiac and Clarkston by sharing system resources between the two campuses to benefit the patients served by both sites.

II. EDUCATION, JOB TRAINING, HOUSING, COLLATERAL DEVELOPMENT

McLaren, working in collaboration with local and regional business, education and political leaders, has invested considerable time and resources to identify and develop a realistic set of programs and initiatives designed to strengthen health care and educational resources available in and around Pontiac. These include:

- McLaren, in conjunction with a state university, will develop higher education programs and curriculum for students interested in careers in health care that will be housed in classroom space provided by McLaren at the Pontiac campus.

- McLaren will construct health care learning simulation labs dedicated for clinical learning for the health care education program.

- McLaren brokered a partnership arrangement for career ladders identified with area educational institutions including Oakland schools, Pontiac schools and a local community college.

- McLaren, through its partnerships with real estate firms, will develop student and workforce housing in downtown Pontiac. Also contemplated is recruitment of collateral retail tenants such as a cyber café, restaurant, grocery store, bookstore, fitness/wellness center, as well as a child care provider.

- The McLaren - Oakland Riley Foundation raised $750,000 which will be designated for use as scholarships awarded to Pontiac children.

- McLaren will create educational programs for faculty development, advancement and patient teaching.

III. STRATEGIC PLAN FOR MCLAREN - CLARKSTON

McLaren - Clarkston is designed to deliver the full continuum of health care services using state of the art technologies to provide prevention, diagnosis, treatment and cure at one site. As the area's only comprehensive, one-stop health care destination, the McLaren – Clarkston campus is located on 80 acres at the corner of Sashabaw Road and Bow Pointe Drive in Clarkston. The $500 million project is being built in two phases.

PHASE I (Completed 2009)

McLaren Health Care opened Phase I of McLaren – Clarkston in May of 2009 with an initial investment totaling $100 million. Over 350 people are employed at this site with over 500 jobs created during the construction. The key components of Phase I are the 135,000 square foot Clarkston Medical Building and the 42,000 square foot McLaren Cancer Institute – Clarkston featuring a five acre garden of healing and renewal.

Located within the new Clarkston Medical Building is the Clarkston Medical Group (CMG). CMG is Clarkston's oldest and largest primary medicine group practice under the leadership of Dr. James O'Neill and Dr. Tim O'Neill. CMG employs 15 primary care physicians and over 125 support staff. The Clarkston Medical Building is also home to 64 physicians representing a wide range of specialty care services.

Other services in this building include a 24-hour urgent care center, a 17,000 square foot ambulatory surgery center with three operating rooms, a pharmacy, clinical laboratory services, home medical equipment, a breast care center featuring the area's only digital mammography unit, bariatric center, physical therapy, sports medicine, fitness center, diagnostic sleep clinic, wound care clinic in addition to a comprehensive diagnostic imaging center with CT, MRI and PET/CT modalities.

Also opened in May 2009 is the area's only dedicated, freestanding comprehensive cancer center. The McLaren Cancer Institute – Clarkston provides state of the art radiation therapy, advanced medical oncology, mobile PET/CT imaging, education programming, patient navigator and family support services.

The award winning five acre Garden of Healing and Renewal provides peaceful, soothing surroundings in which to focus healing energies, talk privately and build strength. The garden features an oasis of fountains and sculptures, sitting areas and beautiful paths to encourage exercise and curative reflection. The lush landscaped campus is open for the community to use and enjoy.

PHASE II

The second phase of McLaren - Clarkston will include the development of a 200 bed hospital with all of the associated essential patient care services. McLaren conducted exhaustive research to arrive at the most appropriate and economically feasible development plans for all portions of the project. Phase I far exceeded expectations, making the Clarkston campus a health care destination for outpatient services in the planning area. Further, historical health utilization data shows an unmet need for continued development of the site to include inpatient services.

INPATIENT VOLUME GENERATED FROM CLARKSTON SERVICE AREA

According to data supplied by the Michigan Health and Hospital Association, the Clarkston service area generated 23,649 admissions to an acute care hospital during the 12-month period of July 2010 to June 2011. Assuming an average of 5 days length of stay per admission, a 200 bed acute care hospital located in Clarkston would need to capture only 37% of this volume in order to operate profitably at 60% occupancy. Even operating at 80% occupancy, the proposed facility would only need to capture 49% of this volume. Further, Thomson Reuters projects this annual volume to increase to over 30,000 admissions per year by 2025 based on continued growth in population and age-related increases in utilization.

CONSUMER SUPPORT FOR CLARKSTON PROJECT

A consumer survey of Clarkston area residents was performed by Intellitrends, a Clarkston based market research firm. When asked, "How important do you feel it is to have a full-service hospital in your community?" greater than 80% of responses rated this as "important".

ECONOMIC IMPACT

McLaren estimates that the Clarkston project, when complete will have created approximately 4,000 new jobs. Every 15 new jobs results in $3 million dollars in economic impact (Oakland County and The Federal Reserve Board) to the area in the form of wages, state and local taxes in addition to the multiplier effect of these dollars moving through the local economy. Based on this estimate, these jobs will generate $600 - $800 million in annual economic impact.

CON RESTRAINTS

In spite of all of the positive outcomes listed above, the Hospital Bed Standard Advisory Committee (SAC) and ultimately the CON Commission produced a set of CON Review Standards for Hospital Beds that prohibit McLaren from reducing the number of beds in Pontiac, addressing the population growth in Clarkston, moving beyond the current 2 mile limit, creating 4,000 jobs, and investing an additional $350 million dollars into the Michigan economy.

The bed need methodology recommended by the SAC and approved by the Commission has essentially preserved the status quo. The formula is based on patient days from existing facilities and is then compared to the total number of existing beds from those facilities. This methodology will always result in excess beds. It will never show a need for new beds in a given area. It fails to account for population shifts and makes capacity a proxy for access.

In addition to the limitations outlined above, the SAC set forth an arbitrary bed reduction requirement. The bed reduction language has no statistical basis and puts communities served by aging facilities, such as McLaren – Oakland in Pontiac, at a disadvantage. The language further complicates a potential bed move that would position Pontiac with the appropriate number of beds and allow the people of Clarkston and surrounding communities to be served by an acute care hospital.

The following proposal to regulate the structure for relocating existing hospital beds was submitted by McLaren at the November 16, 2011 Hospital Bed SAC.

> The proposed methodology this committee is being asked to consider captures an historical picture of where hospital beds are in the State of Michigan and relies only on hindsight over foresight.
>
> This methodology, like previous methodologies created by previous Standards Advisory Committees, groups and protects existing hospitals instead of projecting any future shifts in health care delivery needed to meet shifts in population. In fact, it creates a hospital grouping with a "bed surplus" that includes nearly 700 beds created by the legislature and or the courts.
>
> This lack of foresight is further complicated by the proposals for bed reduction which discourage quality improvements to aging infrastructure and undermine a number of community hospitals.
>
> Adopting the proposed language will continue to mean that the only new hospitals ever built in the State of Michigan will be approved by the Legislature or the courts and not the CON

Commission. We can all look forward to more new, overbuilt towers at existing locations because that is the only permissible construction. And we can expect that certain communities will be abandoned entirely because the cost to maintain aging infrastructures with no ability to relocate far exceeds any benefit.

This committee had an opportunity to consider a simplified hospital bed regulatory framework that addresses community needs and worked toward developing the right-sized hospitals as opposed to maintaining the status quo.

As a result, we supported simplifying the Hospital Bed Standards to include the following provisions:

Regulatory structure for relocating existing hospital beds:

- Reduce restrictions on CON for relocating hospital beds to a new site
  - If a hospital elects to relocate beds to a new site it must demonstrate:
    - Financial viability with regard to the entire project
    - Conclusive positive community need assessment for both the proposed hospital site that is receiving the beds and the hospital giving up the beds
      - Significant community benefit with a financially viable plan for reuse of existing facility
      - Existing facilities cannot close to move to a new facility
    - No additional beds in Michigan
    - Maintain existing payer contracts for at least five years
    - Delicense at least 10% of existing facility's beds
    - Proposed new hospital sites may not be approved within five miles of existing acute care hospitals, nor within the same county as single community providers

The SAC was scheduled to meet until December 20, 2011 but decided to end deliberation on the Hospital Bed Standards early and make November 16, 2011 their final meeting. There should have been an additional 30 days to fully consider the proposal. The main criticism from opponents of the proposal was that it would increase healthcare costs. As noted by Robert Cimasi in his paper, **Duped by Cries of Duplication**, "There has been no significant or empirical data that establishes that healthcare facilities or items of medical equipment actually, in and of themselves, raise either utilization or overall healthcare

costs."[1] In addition, in the report prepared for Michigan Department of Community Health by Conover and Sloan, the authors concluded that "With its roots in the rapidly disappearing cost based, third party reimbursement mechanisms of the past, CON is becoming clearly less relevant as a cost containment mechanism. Primary justification for CON, therefore, must rest on its ability to improve or maintain quality and/or access to care."[2] The McLaren proposal would indeed have improved quality and, most importantly, improved access to care through improved distribution of existing hospital beds.

In summary, the SAC Hospital Bed Standards, now enacted, continue to preserve existing franchises, continue to assure that the only new hospitals built in Michigan will be by Legislative or court action, encourage excess spending on overbuilt patient towers at existing locations, and subject aging urban communities to a separate standard of care. We can expect that certain communities will be abandoned entirely because the cost to maintain aging infrastructures instead of relocating them will far exceed any benefit. The implication further exists that restricting the growth of new facilities could become a burden on healthcare reform itself by exacerbating the growing access problem driven by the demand generated by the newly insured. It is no coincidence that, in the face of all the negative aspects of the proposed standards, the most outspoken opponents of hospital bed reform are hospitals themselves. The adopted standards allow them to have a monopoly on hospital beds in a given area.

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[1] Cimasi, Robert James (April 2002). Duped by Cries of Duplication: The Failure of Certificate of Need Regulations. Health Capital Consultants, 4.

[2] Conover, Christopher J., Sloan, Frank A. (May 2003). Evaluation of Certificate of Need in Michigan. Volume I: Final Report. Center for Health Policy, Law and Management. Terry Sanford Institute of Public Policy. Duke University, vi.

A. Exhibit 1 – McLaren Health Care Village at Clarkston Services

McLaren Health Care Village at Clarkston is the area's premier destination for outpatient care, offering primary care services, 24-hour urgent care services and more than 25 medical specialties at one convenient location. There's even a revitalizing five-acre garden for patients and the public to enjoy.

Call today, or ask your doctor about receiving care at McLaren Health Care Village at Clarkston.

CLARKSTON MEDICAL BUILDING

Advanced Allergy and Asthma
248.384.8310

Advanced Psychiatric Intervention, PLC
248.681.0623

Associated Radiologists of Clarkston
248.620.9199 or 248.620.5012

Cardiology & Vascular Associates
248.625.5550

Clarkston Dermatology (Cosmetic)
248.620.3376

Clarkston Dermatology (Medical)
248.620.3376

Clarkston Gastroenterology
248.442.0800 or 866.799.0800

Clarkston Medical Group
248.625.CARE (2273)

Clarkston Surgery Center
248.922.4800

Clarkston Surgical Specialists
248.384.8200

Clarkston Urgent Care
248.625.CARE (2273)

Infectious Disease Center, PC
248.625.9900

McLaren Bariatric Institute
248.922.6830

McLaren Breast Center
248.922.6810

McLaren Home Medical
248.922.6850

McLaren Physical Therapy, Sports Medicine & Fitness Center
248.922.6820

McLaren Sleep Diagnostic Center
248.922.6840

McLaren Wound Care Clinic
248.922.6860

Michigan Center for Orthopedic Surgery
248.620.2325

Michigan Institute of Urology, PC
248.620.6660

Michigan Kidney Consultants, PC
248.620.4000

Michigan Vascular Center & Michigan Vascular Access Center
248.620.3900

Neurology Consultants of Clarkston, PC
248.208.2161

Neuro Pain Consultants, PC
248.620.9310

North Oakland ENT Centers
248.620.3100

Oakland Eye Care–Ophthalmology & Optical
248.922.0400

Ellen Ozolins, MD, PC
Plastic & Reconstructive Surgery
248.922.9066

Pine Knob Pharmacy
248.384.8050

Pulmonary & Critical Care Medicine Consultants, PC
248.922.9283

VeinSolutions
248.620.9901

Stephen Werner, MD, & Michael Quinn, MD
Orthopaedic Surgery
248.332.8391

Peter Wilusz, DPM
Podiatry
248.922.6000

Women's Healthcare Associates PLLC
248.384.8020

GLCI–CLARKSTON

Great Lakes Cancer Institute at Clarkston
248.922.6600

Pain Management Specialists of Southeast Michigan
888.719.0008

FOCUS ON:

Great Lakes Cancer Institute

Free Colorectal Cancer Screening

March is Colorectal Cancer Awareness Month, and you need to know that Great Lakes Cancer Institute is providing free colorectal cancer testing kits that help screen for this deadly disease.

If you are 50 or older or have a family history of colorectal cancer, call toll free **866.696.GLCI (4524)** to request your free kit today.

It could help detect colon cancer and save your life!

McLAREN
HEALTH CARE VILLAGE *at* CLARKSTON

Bow Pointe Drive, off Sashabaw between Maybee and Waldon

mclarenclarkston.org

Exhibit 2 – Clarkston Service Area Admissions (July 2010 – June 2011)

Hospital Market Share and Inpatient Volumes Time Period: July 2010 - June 2011 *Source: Michigan Health and Hospital Association*	Clarkston Service Area Discharges	 Market Share
Total Discharges from Defined Area	23,649	100%
St. Joseph Mercy Oakland	7,604	32.2%
POH Regional Medical Center	2,353	10.0%
Crittenton Hospital Medical Center	2,813	11.9%
Genesys Health System	1,853	7.8%
McLaren Regional Medical Center	158	0.7%
All Others	8,868	37.5%

Source: Michigan Health and Hospital Association

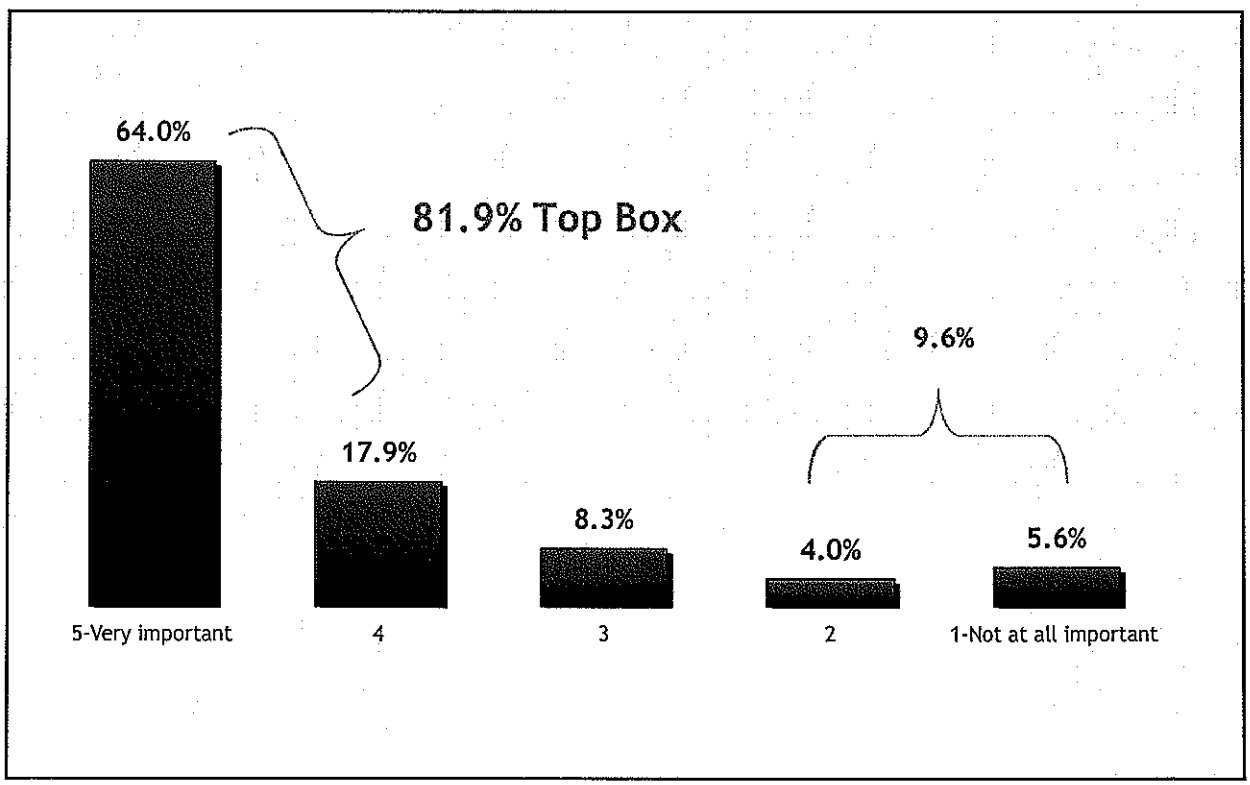
Exhibit 3 – Clarkston Service Area Volume Growth Projections to 2025

Service Line	2010 Cases	2015 Cases	2020 Cases	2025 Cases	% Change 2010-2015	% Change 2015-2020	% Change 2020-2025
Alcohol & Drug Abuse	163	167	172	177	2.5%	3.2%	2.9%
Cardio\Vasc\Thor Surgery	1,231	1,405	1,581	1,766	14.2%	12.5%	11.7%
Cardiovascular Diseases	2,515	2,915	3,324	3,738	15.9%	14.0%	12.5%
ENT	174	187	201	213	7.4%	7.4%	6.3%
General Medicine	4,868	5,388	5,920	6,432	10.7%	9.9%	8.6%
General Surgery	2,154	2,360	2,571	2,773	9.6%	9.0%	7.9%
Gynecology	511	526	540	550	2.8%	2.8%	1.7%
Nephrology/Urology	1,324	1,504	1,689	1,874	13.6%	12.3%	11.0%
Neuro Sciences	1,497	1,673	1,852	2,031	11.7%	10.7%	9.7%
Obstetrics Del	2,573	2,553	2,526	2,403	-0.8%	-1.1%	-4.9%
Obstetrics ND	261	259	254	241	-0.8%	-1.7%	-5.2%
Oncology	591	658	727	794	11.3%	10.5%	9.2%
Ophthalmology	37	40	43	46	8.3%	7.1%	7.1%
Orthopedics	2,734	3,048	3,371	3,691	11.5%	10.6%	9.5%
Pulmonary Medical	2,117	2,380	2,649	2,917	12.4%	11.3%	10.1%
Rehabilitation	473	561	650	743	18.5%	15.9%	14.3%
Grand Total	23,223	25,623	28,071	30,389	10.3%	9.6%	8.3%

Source: Thomson Reuters

Exhibit 4 – Clarkston Consumer Perception Study

How important do you feel it is to have a full-service hospital in your community?



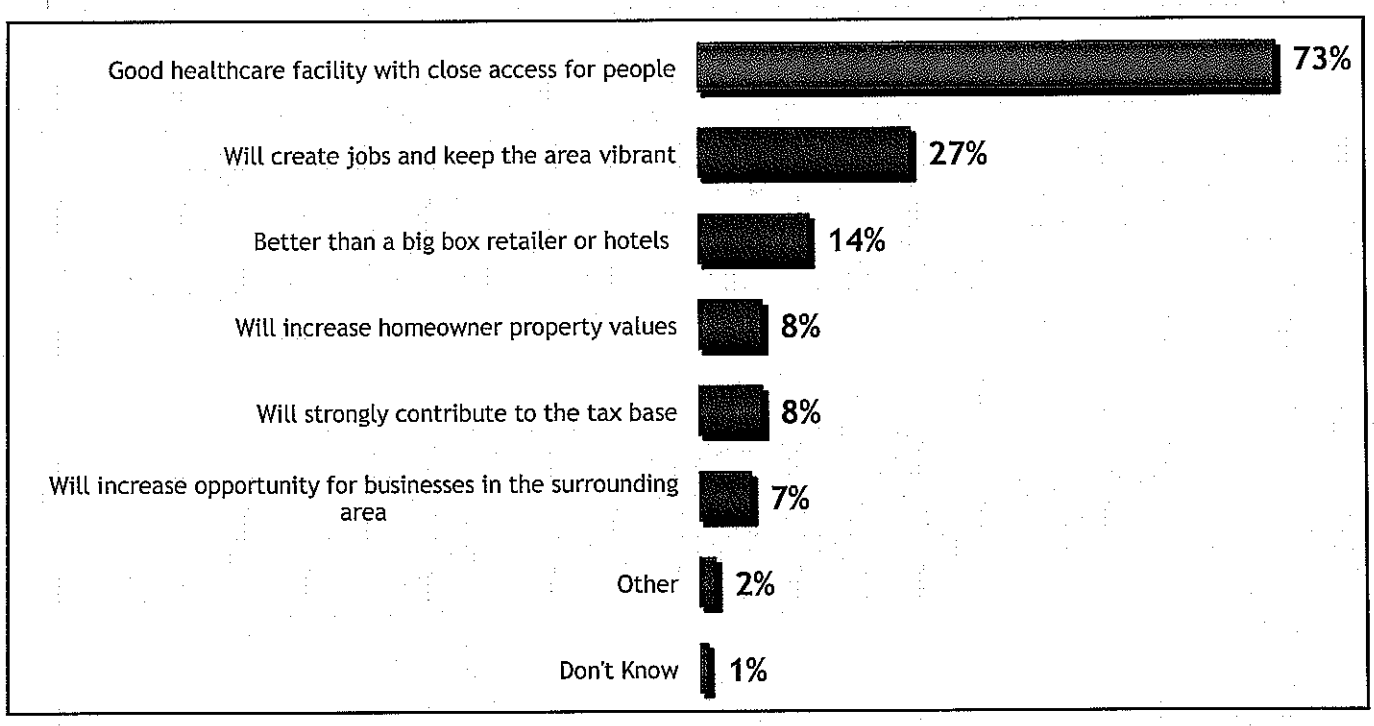
Source: Intellitrends

General Findings

- Overall, 82% feel that having a full service hospital in their community is of top box importance
- 73% of those that feel positively about the new facility are most motivated by 'good healthcare facility with close access for people'
- Currently only 42% consider the access to a full a service hospital facility in their community as 'Excellent'

Exhibit 4 – Clarkston Consumer Perception Study (cont.)

Reasons behind POSITIVE feedback (4 or 5 rating):



Source: Intellitrends

Exhibit 4 – Clarkston Consumer Perception Study (cont.)

In your community, how would you rate...

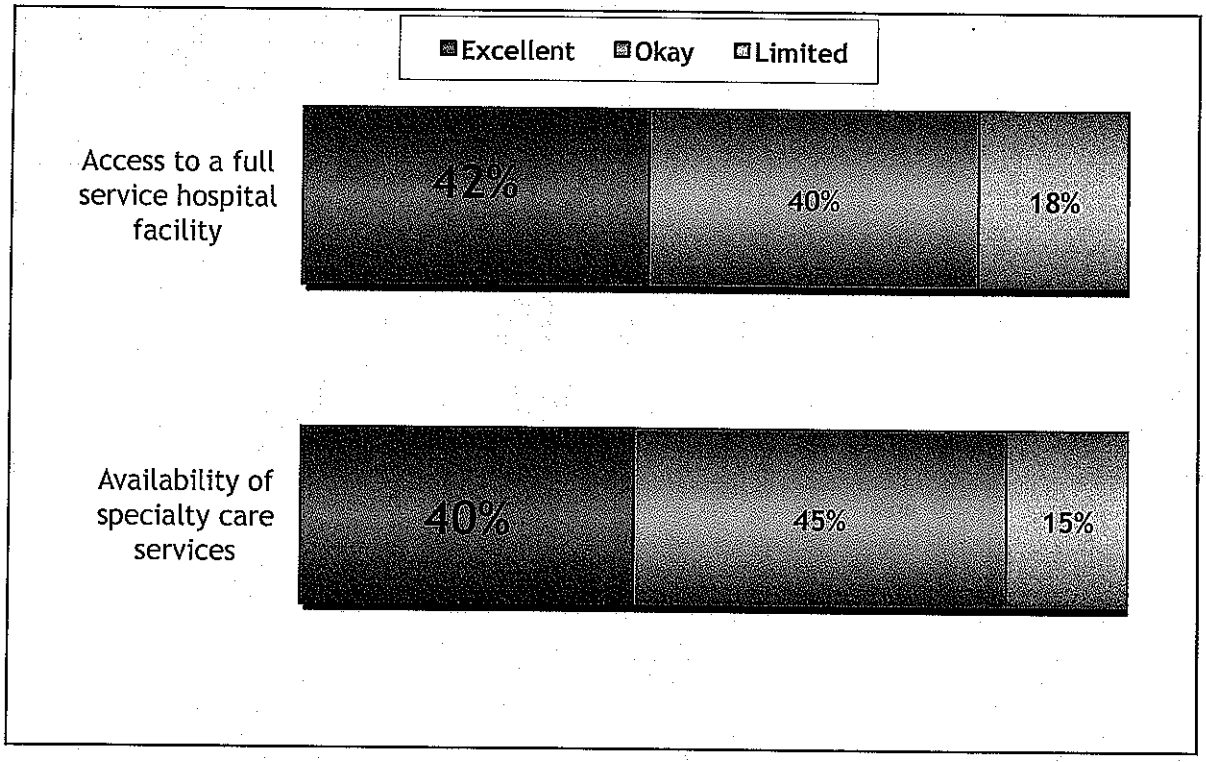
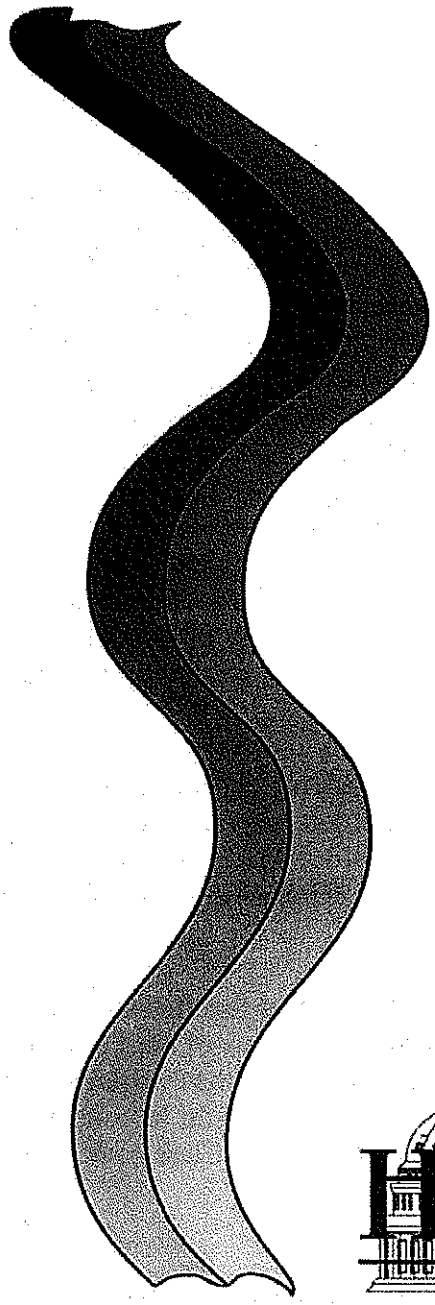


Exhibit 5 – Ernst & Young LLP Tax Comparison Study

Follows



A Brief Analysis of McLaren Health Care Pontiac and Clarkston Campus Projects

Gary Wolfram, Ph.D.

August 7, 2012

Hillsdale Policy Group, Ltd.

Specializing in Taxation & Public Policy Analysis

A Brief Analysis of McLaren Health Care Pontiac and Clarkston Campus Projects
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Executive Summary

McLaren Health Care is a fully integrated Michigan-based health network, committed to quality, evidence-based patient care and cost efficiency. McLaren has a broad footprint throughout the State of Michigan with a history of investing in communities through enhanced access to healthcare resources. As part of its statewide development initiative, McLaren proposes to complete Phase Two of its Clarkston campus by adding 200 hospital beds to meet growing demand in the area and alter its Pontiac campus by reducing the excess hospital bed capacity and adding an outstanding educational facility to the campus. The proposal would also make the Pontiac campus a cutting-edge provider of primary care.

The economic benefits to the state and to the region from both projects are substantial. The Pontiac campus restructuring will be a $9 million investment in program enhancement and the near-term addition of 12 employees as part of the educational facility. Pontiac will particularly gain from long-term economic benefits of providing the opportunity for 100 students per year to receive training for and knowledge of the expanding health care industry through the proposed educational facility.

The $300 million Clarkston Phase Two expansion will result in an increase in direct employment of 1,300, with an annual payroll of approximately $68 million, and an additional 250 construction jobs during the three-year period of construction. McLaren estimates the multiplied economic effect of the Clarkston expansion to be 4,000 new jobs and $600-$800 million in annual economic impact.

Unfortunately, the economic benefits of restructuring the hospital facilities in order to meet changing needs cannot be accomplished under the current certificate of need program. As a consequence, either approval by the Governor or an amendment of the certificate of need program by the Legislature will be needed to allow McLaren to transfer its beds from Pontiac to Clarkston and accomplish its improvements to both the Pontiac and Clarkston campuses.

I. Introduction

The McLaren health care system includes nine hospitals, ambulatory surgery centers, imaging centers, freestanding dialysis centers, a regional network of cancer centers and providers, an employed primary care physician network, assisted living facilities, commercial and Medicaid HMOs, home health care and hospice, durable medical equipment, retail pharmacy services, and a wholly-owned medical malpractice insurance company. McLaren has 17,400 employees and more than 10,000 network physicians.

McLaren Health Care has been ranked in the top 25 integrated health care systems in the

United States for the last 10 years. With more than $4.0 billion in annual revenue in 2010 and an **Aa** rating from Moody's Investor Services and **AA-** from Fitch Ratings, McLaren Health Care has sustained a revenue growth rate of 20% per year for nearly 20 years. McLaren has been able to accomplish such a record through correctly anticipating changes in the health care market and focusing on innovation in the provision of health care.

McLaren proposes to respond to increased demand for health care services in the Clarkston area by completing the second phase of the development of its Clarkston campus. This will include a 200-bed hospital, additional medical office buildings, and an outpatient cardiovascular center.

In response to declining need for hospital beds and an acute need for improved educational services in Pontiac, McLaren would reduce its bed capacity at its Pontiac campus and establish a new and exciting educational program for high school students, as well as improve the mix of health care services to Pontiac residents.

II. Clarkston Campus Expansion: State of the Art Facility and Improved Services

McLaren Health Care Village at Clarkston represents the largest ground-up development in the history of the corporation. The $500 million health care village, located on 80 acres of prime real estate in northern Oakland County, is being developed in three phases. Phase I opened in May 2009. Phase II proposes a 200-bed acute care hospital, two additional medical office buildings, and a comprehensive outpatient cardiovascular center.

The first phase of the Clarkston campus is a state of the art facility on 80 acres that includes a 138,000 sq. ft. medical office building, a 45,000 sq. ft. freestanding cancer center, and a 5-acre Garden of Healing and Renewal. The Clarkston Medical Building (CMB) was uniquely designed to provide its community with medical care for the entire family — from infants to adults. Primary care board-certified physicians of the Clarkston Medical Group include pediatrics, family medicine, and internal medicine. The urgent care center is open at all times and is staffed by board-certified emergency medicine physicians.

Clarkston Medical Building is home to over 20 medical specialists, on-site radiology with 64-slice CT scanner, outpatient surgery center, on-site pharmacy and laboratory, and diagnostic services of McLaren Regional Medical Center in the Centers for Breast, Sleep, Bariatric and Physical Therapy. Also on the campus is the Great Lakes Cancer Institute, which employs the latest radiation oncology technology for cancer treatment.

While Pontiac has suffered a substantial decline in population and suffers from an excess of hospital bed capacity, the Clarkston service area has been growing, and the demand for medical services, in particular hospital beds, is increasing.

A 2011 Thomson Reuters bed-need study demonstrated a need for 161 beds in the Clarkston market by 2015. McLaren - Oakland can meet this demand and maintain at least 80% occupancy in Clarkston. According to data supplied by the Michigan Health and Hospital Association, the Clarkston service area generated 23,223 admissions to an acute care hospital during the 12-month period of July 2010 to June 2011. Thomson Reuters projects this annual volume to

increase to over 30,000 admissions per year by 2025 based on continued growth in population and age-related increases in utilization, which would support an additional 200 bed hospital.

Table 1
Clarkston Service Area Growth Projections

Service Line	2010 Cases	2015 Cases	2020 Cases	2025 Cases	% Change 2010-2015	% Change 2015-2020	% Change 2020-2025
Alcohol & Drug Abuse	163	167	172	177	2.5%	3.2%	2.9%
Cardio\Vasc\Thor Surgery	1,231	1,405	1,581	1,766	14.2%	12.5%	11.7%
Cardiovascular Diseases	2,515	2,915	3,324	3,738	15.9%	14.0%	12.5%
ENT	174	187	201	213	7.4%	7.4%	6.3%
General Medicine	4,868	5,388	5,920	6,432	10.7%	9.9%	8.6%
General Surgery	2,154	2,360	2,571	2,773	9.6%	9.0%	7.9%
Gynecology	511	526	540	550	2.8%	2.8%	1.7%
Nephrology/Urology	1,324	1,504	1,689	1,874	13.6%	12.3%	11.0%
Neuro Sciences	1,497	1,673	1,852	2,031	11.7%	10.7%	9.7%
Obstetrics Del	2,573	2,553	2,526	2,403	-0.8%	-1.1%	-4.9%
Obstetrics ND	261	259	254	241	-0.8%	-1.7%	-5.2%
Oncology	591	658	727	794	11.3%	10.5%	9.2%
Ophthalmology	37	40	43	46	8.3%	7.1%	7.1%
Orthopedics	2,734	3,048	3,371	3,691	11.5%	10.6%	9.5%
Pulmonary Medical	2,117	2,380	2,649	2,917	12.4%	11.3%	10.1%
Rehabilitation	473	561	650	743	18.5%	15.9%	14.3%
Grand Total	23,223	25,623	28,071	30,389	10.3%	9.6%	8.3%

Source: Thomson Reuters

McLaren sees an expansion in patient days in the Clarkston service area of 14,300 between 2011 and 2016, and an additional 13,000 between 2016 and 2021. The expected increase in adjusted occupied beds is 89 in 2011-2016 and 79 more in the period 2016-2021, for a total of 168 average occupied beds. This expansion in demand for health care facilities will be driven by general population increase in the Clarkston area, aging of the population, and changes in insurance coverage, some of which will be an outcome of health care reform

The Clarkston expansion will meet growing demand rather than draw patients from existing facilities. Thomson Reuters found, in analyzing the combined Clarkston Oakland County service area:

"It would not appear that the development of a new facilty in this market would result in a loss of jobs for any one facility but rather that the incremental volume projected would support a significant increase in job opportunities across existing and new facilities."[1]

III. The Pontiac Campus Redevelopment: Service Retention and Realignment and Educational Opportunity

As part of the expansion of health care services into the Clarkston service area, McLaren would change the character of its Pontiac facility. McLaren would effectively move 200 beds from its

[1]Thomson Reuters, "FTE Impact Analysis for McLaren Health-Clarkston Project", pg. 2.

underutilized Pontiac facility to its Clarkston facility and develop its Pontiac facility in a fashion more fitting with the change in the market.

In 2007, POH Regional Medical Center became a member of the McLaren Health Care system. Now named McLaren-Oakland, the hospital includes both the Pontiac campus and the Clarkston campus. The burden of uncompensated care in Pontiac was in the process of overwhelming the Pontiac facility when McLaren took it into the McLaren system. As a result, valuable medical services have been provided to the Pontiac community that would not have been available otherwise.

The Pontiac area has changed substantially over the last several decades. Between 1970 and 2010, the City of Pontiac's population decreased 30% from 85,279 to 59,515 (2010 U.S. Census). At the same time, Independence Township, within which the City of the Village of Clarkston is located, has seen its population double. This has resulted in a substantial shift in demand for hospital beds and other health services to which McLaren Health Care would like to respond.

McLaren - Oakland maintains 308 licensed acute care hospital beds and 20 psychiatric beds at its downtown Pontiac site. The facility has recently received approval to add an additional 7 psych beds, bringing the total bed count to 335. This site typically maintains an average census of 97 admitted patients. McLaren proposes to retain 108 licensed acute care beds and the 27 psychiatric beds for a total of 135 beds at that location resulting in an average occupancy of 90%. This will allow quality services to be maintained at a cost that is affordable to residents. Additionally, the Pontiac hospital will continue inpatient and outpatient medical and surgical services and remain a Level II trauma care provider.

A 2011 Thomson Reuters bed-need study demonstrated that the Pontiac market will require 385 licensed beds to meet market demand in 2015. Currently, 1,024 licensed beds serve the Pontiac market – an oversupply of 639. It is obvious that a reduction in hospital beds in Pontiac is needed, and McLaren is willing to do its part by redistributing 200 of the beds to an underserved Clarkston market. However, Pontiac has two additional acute care hospitals that have held on to unused licensed beds, largely contributing to the projected excess. As a result, if McLaren is not allowed to move its beds from the declining market of its Pontiac campus to the increasing market of its Clarkston campus, then it is possible that the Pontiac campus will be sized so inefficiently that it will not make economic sense for it to remain open.

A potential closure of the Pontiac campus is an important consideration because the McLaren facility serves the majority of the Medicaid and uninsured population of the city. Not allowing McLaren to efficiently size its facility could lead to its closure, which would put a significant financial burden on the community and surrounding facilities.

McLaren proposes to improve the Pontiac campus in ways that will both advance the health care services available to Pontiac residents and provide important educational services. First, during 2012, McLaren - Oakland will make capital investments to support the growth and expansion of key health care services at the Pontiac Campus including, but not limited to, a nearly $9,000,000 investment in program enhancement for cardiovascular services, surgery, endoscopy, geriatric psychiatry, trauma, and infrastructure.

It should be noted that McLaren does not envisage a reduction in personnel from the reduction in number of beds, as personnel will be used to provide the different services that will be available to Pontiac residents.

This expansion will be consistent with McLaren's goal of providing a continuum of care. Rather than expend its resources in maintaining a facility that is too large for its needs, McLaren could expand other services that will improve the health care of the residents of Pontiac.

Access to basic primary care services is the cornerstone of a healthy community. McLaren - Oakland will continue to expand the primary care medicine base in the city of Pontiac by increasing the number of Family Practice physicians serving the market, including increasing the size of the current Federally Qualified Health Center. McLaren - Oakland will be able to provide comprehensive services to both Pontiac and Clarkston by sharing system resources between the two campuses to benefit the patients served by both sites.

The ability to maintain the existing Pontiac facility in the face of declining population and declining demand is important. As an example, when McLaren took over the Mt. Clemens Regional Medical Center in 2006, the facility was on the verge of closing. It had lost $70 million in the prior four years. Within a year, McLaren had turned a profit for the hospital, now called McLaren-Macomb. The hospital's improved financial situation allowed it to recruit 28 primary care physicians by 2009.

McLaren-Macomb opened a cancer center in 2008, expanded the heart center, and in December purchased the latest daVinci surgical robot for urology, gynecology, general surgery, and open heart. In 2010, McLaren-Macomb became Macomb County's only certified level-two trauma center.

Had McLaren not intervened, it is likely that the Mt. Clemens Regional Medical Facility would have closed with the attendant loss of jobs and health care services. In the same fashion, the ability of McLaren to reallocate its resources at its Pontiac and Clarkston campuses will allow the health care of everyone in Oakland County to be better served and the economic climate of the area to be improved.

Thus, it is more precise to argue that the reduction in beds at the Pontiac campus is more likely to retain jobs than to reduce jobs, since operating a facility with excess capacity over time will lead to its eventual closing and loss of jobs.

McLaren also proposes to develop the educational component of its Pontiac campus with an exciting new program. McLaren is already heavily involved in health care education. With nearly 500 funded residency and fellowship positions in both allopathic and osteopathic graduate medical education programs, McLaren is one of the largest producers of newly accredited physicians in the country. Consistent with is mission,[2] McLaren would provide educational opportunities at both the K-12 and higher education levels at its Pontiac campus.

The Pontiac campus would see the construction of health care simulation labs for clinical learning for its health care education program. McLaren proposes, in conjunction with a state

[2] McLaren Health Care 2011 Annual Report

university, to develop higher education programs and curriculum for students interested in careers in health care that will be housed in classroom space provided by McLaren at the Pontiac campus. McLaren will create educational programs for faculty development, advancement, and patient teaching.

Through its partnerships with real estate firms, McLaren will develop student and workforce housing in downtown Pontiac. Also contemplated is recruitment of collateral retail tenants such as a cyber café, restaurant, grocery store, bookstore, fitness/wellness center, as well as a child care provider.

McLaren brokered a partnership arrangement for career ladders identified with area educational institutions, including Oakland schools, Pontiac schools, and a local community college. The McLaren - Oakland Riley Foundation raised $750,000, which will be designated for use as scholarships awarded to Pontiac children.

These educational opportunities are exciting for a community that has been in decline for at least forty years. The revamped Pontiac campus will shed unneeded hospital beds that are expensive to maintain and become a center for increased quality of care, and will serve as a center for health care education at all levels. According to the Bureau of Labor Statistics:

> The healthcare and social assistance industry is projected to create about 28 percent of all new jobs created in the U.S. economy. This industry—which includes public and private hospitals, nursing and residential care facilities, and individual and family services—is expected to grow by 33 percent, or 5.7 million new jobs. Employment growth will be driven by an aging population and longer life expectancies, as well as new treatments and technologies.[3]

The Pontiac educational facility will assist in lowering the unemployment rate by improving the skill set of Pontiac area students. Moreover, the exposure of these Pontiac students to the opportunities available in the health care industry will be felt throughout the larger school system. The students who attend this program will learn that there is a wide range of opportunities available to them. They will even become exposed to the operational employment, such as accounting and supervisor positions.

The latest unemployment figures for Pontiac are for March 2012, when the rate was 20%, while for Michigan it was 8.5%. Teenage unemployment is undoubtedly at least 40%, as the national unemployment rate for teenagers is nearly triple the overall unemployment rate.

The educational program in Pontiac is designed in the beginning to provide an opportunity to 50 students. These students will find that, if they work hard and persevere, they can escape the cycle of unemployment and poverty and find the road to prosperity. These students will interact with other students in the schools, and as more students cycle through the program, the McLaren program will provide a beacon of hope that will alter attitudes and improve academic performance for many.

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[3]Occupational Outlook Handbook, Projections Overview at http://www.bls.gov/ooh/About/Projections-Overview.htm.Accessed April 7, 2012.

The Pontiac campus will far better serve the Pontiac community with the expanded educational mission and service than by maintaining an excess inventory of hospital beds. While this is a positive development, more important for Pontiac in the long term is that the services that are provided through the new educational programs will result in an increase in skilled labor in a field that is one of the strongest growth areas of the economy.

The establishment of the educational facilities at the Pontiac campus will result this summer in 20 Pontiac students attending a camp to teach nursing assistants. This will entail adding 12 employees, six by Oakland Schools and six with Oakland Community College. McLaren will add two employees and some of their nurses will be part of the program at Oakland Community College and part of the program at the hospital. The plan is to eventually expand the program to a classroom environment of 50 students per semester or 100 a year.

McLaren has been working with the community for the development of Promise Zone scholarships so poor students can take advantage of higher education without having to travel. The summer camp will demonstrate to Pontiac high school students that staying in school and performing well will result in well-paying jobs. It will show them that there are a myriad of careers, such as in the culinary arts, pastoral care, and accounting that are going to be part of the expansion of health care services in the U.S. economy. It will give 9th and 10th graders an idea of what they must do to prepare themselves for community college and four-year college programs. This will offer a clear and reasonable route from poverty.

Clearly, McLaren is taking a role in leading the economic development of Pontiac rather than retaining a surplus of hospital beds in one community while demographic and technological changes increase the demand for beds in another.

The job skills that will be developed at the facility are crucial to the economic development of Pontiac. Any discussion of economic development leads to the need for a skilled labor force. The increase in human capital that will result from the McLaren plan will provide job skills for local residents and attract additional health care providers to the area.

The establishment of the Pontiac program is part of the McLaren plan designed to help both the Pontiac and Clarkston communities by providing access to the services that result from the changing conditions and demands of both communities.

IV. Employment Effects

The creation of new jobs in an economic area results in extra economic activity through a multiplier effect. The standard analysis is to recognize two effects aside from the direct employment at the facility.[4] One effect is what is sometimes called the supplier effect, which is the effect on the industry that supplies a new facility. For example, if a new health care facility opens, it will purchase supplies, such as medical equipment, from other companies. This added demand on the medical equipment manufacturers will result in an increase in employment in that industry. A second effect is what is sometimes called the re-spending effect. This is the effect

[4] See, for example, Josh Bivens, "Updated Employment Multipliers for the U.S. Economy," Economic Policy Institute, Working Paper No. 268, August 2003. For a further discussion, see SNR Denton and the Lewin Group, The Economic Impact of Office-Based Physicians in Massachusetts, January 2011.

on job creation when workers in the new facility spend their paychecks. For example, workers in a new health care facility may buy lunch at a local restaurant or purchase a house in the community.

There are several ways to estimate these indirect effects on employment, but a standard one is to use the RIMS model of the Bureau of Economic Analysis (BEA). The BEA has created output and jobs multipliers for various industries for various regions. The multiplier most specific to the Pontiac and Clarkston campuses is Oakland County.

Phase One, completed in 2009, has resulted in an increased direct employment of 350 people in addition to 500 construction jobs. Phase Two would result in increased employment of 1300 at the campus, with an annual salary of approximately $68 million, and an additional 250 construction jobs for three years of the project.

McLaren estimates that the Clarkston project, when complete, will have created approximately 4,000 new jobs including the multiplied effect of its direct employment. Every 15 new jobs results in $3 million dollars in economic impact (Oakland County and The Federal Reserve Board) to the area in the form of wages and state and local taxes, in addition to the multiplier effect of these dollars moving through the local economy. Based on this estimate, these jobs will generate $600 - $800 million in annual economic impact.

But the specific multiplier number may not be as important as the economic gain from allowing firms to reallocate their resources to meet the changing demands of the market, and the encouragement of innovation that comes from allowing competition in a market.

V. Economic Gain from Competition

Some might argue that moving 200 beds from the Pontiac campus to the Clarkston campus, thereby retaining jobs in Pontiac, would not result in economic gain because the Clarkston expansion would simply move patients to that facility from existing facilities in the Clarkston area. This argument ignores one of the main effects of market capitalism—innovation and improved services.

The only way that patients might move from an existing facility in Clarkston to the new McLaren facility is if the customer felt he or she was getting better service at McLaren. The replacement of less preferred services and products by more preferred services and products is the key to economic growth. We are not wealthier because we have more tapestries than the kings of the 13th century, but because we have goods and services they could not dream of.

McLaren has a strong record as innovator and supplier of quality service. It established itself as a leader in electronic medical records, not only for budgets and billing but also for health care decision support, clinical analytics, and scenario planning. Its proton beam center is a first for the state of Michigan. Construction of the $65 million facility began in 2010 and is only one of nine in the US. The McLaren-Flint campus recently acquired the most advanced MRI available

worldwide at a cost of $2 million. In 2011, *U.S. News & World Report* ranked four McLaren hospitals among "America's Best Hospitals" in 10 specialty care areas.[5]

These are but a few examples of how McLaren has developed a health care delivery system that provides high quality service at lower cost. The expansion of the company has allowed it not only to fund the acquisition of expensive new technology, but also to find less expensive ways to deliver what might be considered mundane care. For example, by purchasing one million bandages rather than 100,000 bandages, the per-unit cost is driven down significantly. The demands of modern health care for supply inventory are large, and the ability to purchase at scale reduces the cost of health care for McLaren's customers.

The purpose of any business is not to create jobs; it is to provide goods and services that consumers value more than the value of the resources used in production. After all, if we wanted to simply produce additional jobs, we could find very labor intensive ways to produce things. Indeed, we find that innovation will generally reduce the amount of resources needed to produce something, including labor.

The economic benefit of the Clarkston campus expansion goes well beyond what would be the standard analysis of number of jobs or payroll multiplied by RIMS multipliers. The greatest benefit is the innovation from a new competitor in the market. Certainly Facebook has an economic addition far beyond what its number of employees multiplied by some factor derived from an economic model would predict. The same is true for the restructuring of the Pontiac campus and the expansion of the Clarkston campus.

VI. Certificate of Need

While it is not the purpose of this paper to discuss certificate of need, the McLaren proposal to move beds from its Pontiac facility to its Clarkston facility warrants a brief discussion of the topic. During the 1960s and 1970s, states adopted statutes that required hospitals that want to expand services and undertake capital expenses to obtain a certificate of need. The idea was that this regulatory interference in the market place would limit increases in hospital costs.

Anyone familiar with the public choice literature will immediately see that certificate of need regulation will in effect result in the supply of hospital beds being determined through the political process rather than through the market process, with all the attendant problems. In particular it will hamper the response of supply of medical services to changes in consumer demand and result in oversupply of hospital beds in some areas and undersupply in others.

The academic literature supports the proposition that the use of certificates of need not only interferes with the efficient allocation of hospital services, but also fails to reduce hospital costs. To quote but two studies

(i) A Federal Trade Commission Report noted: "The study thus finds no evidence that CON (Certificate of Need) programs have led to the resource savings they were designed to promote, but rather indicates that reliance on CON review may raise hospital costs."[6]

[5] From McLaren Health Care 2011Annual Report, pg. 7

(ii) A study by Duke University professors conducted for the Michigan Department of Community Health found that: "Upon reviewing a large body of national and Michigan-specific material regarding acute care CON, including an analysis of what happened in states that dropped acute care CON, the Center (for Health Policy Law and Management at Duke University) found that there is little evidence that CON results in reduction in costs and some evidence to suggest the opposite..."[7]

Unfortunately, the economic benefits of restructuring the hospital facilities in order to meet changing needs cannot be accomplished under Michigan's current certificate of need program as it is being interpreted. As a consequence, either approval by the Governor or an amendment of the certificate of need program by the Legislature will be needed to allow McLaren to transfer its beds from Pontiac to Clarkston and accomplish its improvements to both the Pontiac and Clarkston campuses.

VII. Summary

McLaren Health Care's plan to reallocate its hospital beds from its overcapacity Pontiac facility to its Clarkston campus and to develop the Pontiac campus to a more efficient health care delivery location and an educational center will be a boost to the local economies of both Pontiac and Clarkston. It will provide long-term advantages to Pontiac citizens by redesigning health care delivery in the area to meet the changing demands of customers, and by increasing the human capital of its citizens, providing the opportunity for many at-risk high school students to join one of the fastest growing industries in America.

The expansion of the Clarkston campus will provide innovative services and meet the needs of an expanding population of consumers. It will improve the health care of citizens in the Clarkston area and will lead to innovations in health care that will be of value to all the citizens of Michigan

The economic benefits of the McLaren plan go well beyond the customary numbers that are usually found in regional economic models. The track record of McLaren as one of the most innovative and efficient providers of health care in the country demonstrates the advantage to the citizens of Oakland County and the rest of Michigan of allowing the company to go forward with its planned restructuring and expansion of its Michigan campuses.

These benefits cannot be achieved if McLaren is constrained in its restructuring by Certificate of Need restrictions. Removing this constraint will not only make possible the benefits for this particular project, but will also allow the health service community in Michigan to better respond to changing demographic and technological conditions.

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[6]Daniel Sherman, "The Effect of State Certificate of Need Laws on Hospital Costs: An Economic Policy Analysis, Executive Summary," Federal Trade Commission Report, January 1988.

[7] Christopher Conover and Frank Sloan, Evaluation of Certificate of Need in Michigan, Volume 1: Final Report, A Report to the Michigan Department of Community Health, Center for Health Policy, Law, and Management, Duke University, May 2003, pg. vi of executive summary.

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AN ANALYSIS OF THE CONSEQUENCES OF CERTIFICATE OF NEED[1]

WHITE PAPER REPORT PREPARED FOR MCLAREN HEALTH CARE

Prepared by
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Abstract

While Certificate of Need (CON) legislation has long been intended to balance quality, cost, and access in healthcare, the outcomes associated with the regulation appear to be mixed. This study collects and analyzes data from three publicly available secondary sources; the American Hospital Directory, the United States Census Bureau, and the American Health Planning Association to inform three pressing questions facing policy makers, healthcare executives, and patient advocates. First, how, if at all, do CON and non-CON states differ? Second, how, if at all, does hospital performance differ in CON and non-CON states? Finally, how, if at all, is the healthcare experience (cost and access) different for residents in CON and non-CON states?

These findings suggest that CON does not appear to have a substantial effect at the state level in managing demand, capacity, volume activity or throughput, or healthcare spend/cost. At the same time for hospitals, these results show that facilities in CON states enjoy larger size or capacity, higher volume activity or throughput, and better financial performance than hospitals in non-CON states. For residents, while cost and utilization appear to be statistically the same regardless of their state's CON status, access to care is more constrained in CON states. While the evidence found herein for increased hospital volume associated with CON may support the claims of researchers linking volume and quality, these findings appear to provide support for additional evaluation and rethinking of the role of CON in balancing quality, cost, and access.

Background

Certificate of Need (CON) is a state mandated and state specific legislative program broadly aimed at balancing quality, cost, and access to healthcare services within a particular state (Langley et al., 2010). This is achieved primarily by constraining the growth of certain healthcare services (e.g., beds, diagnostic imaging, among others) by employing a needs-based evaluation system, whereby all construction projects involving said services require approval from a state oversight agency (Grabowski and Angelelli, 2004). "In a state with a CON, a healthcare facility is forbidden from undertaking a reviewable project unless it obtains planning agency approval based on review of the project against a set of planning criteria and a finding of community need," (Simpson, 1985: p. 1225).

CON has its roots in the notion of the *market imperfections economic approach* which suggests that in environments "...where both producers and consumers are insulated from [the]

[1] This report was commissioned and financially underwritten by McLaren Health Care.

financial consequences of their decisions, unregulated markets will not yield socially desirable results. In this environment of excess, it was left to the government to provide restrain that market forces would not," (Madden, 1999: p. 1658). The state of New York adopted the first CON in 1964 and in the decade that followed an additional 25 states passed similar CON laws (Simpson, 1985). By 2010, CON laws were enacted in 37 states in the U.S.A. and 30 different healthcare service lines ranging from acute hospital beds to medical office buildings (MBOs) to diagnostic equipment such as ultra-sound units were subject to CON regulation (AHPA, 2011). See tables 1 and 2.

Table 1. States with at least one category of CON in 2010 (AHPA, 2011).

States			
1 Alabama*	11 Iowa*	21 Nebraska	31 South Carolina*
2 Alaska*	12 Kentucky*	22 Nevada*	32 Tennessee*
3 Arkansas	13 Louisiana	23 New Hampshire*	33 Vermont*
4 Connecticut*	14 Maine*	24 New Jersey*	34 Virginia*
5 Delaware*	15 Maryland*	25 New York*	35 Washington*
6 Dist. Of Columbia*	16 Massachusetts	26 North Carolina*	36 West Virginia*
7 Florida*	17 Michigan*	27 Ohio	37 Wisconsin
8 Georgia*	18 Mississippi*	28 Oklahoma	
9 Hawaii*	19 Missouri*	29 Oregon	
10 Illinois*	20 Montana	30 Rhode Island*	

* States with CON for acute hospital beds.

Table 2. Services/equipment covered under CON in 2010 (AHPA, 2011).

Service/Equipment	**Service/Equipment**
Acute hospital beds	MRI scanners
Air ambulance	NICU
Ambulatory surgery centers	Obstetric services
Burn care	Open heart surgery
Cardiac catheterization	Organ transplant
CT scanners	PET scanners
Gamma knives	Psychiatric services
Home health	Radiation therapy
Hospice	Rehab
ICF/MR	Renal dialysis
LTAC	Res care / Assisted living
Lithotripsy	Subacute services
Nursing home beds / LTC beds	Substance abuse
Medical office buildings (MOBs)	Swing beds
Mobile Hi Tech	Ultra-sound

While CON is intended to balance quality, cost, and access (Langley et al., 2010), achievement of the outcomes associated with the legislation appear to be mixed. For example, CON is expected to lead to higher procedure volumes per facility, and higher procedure volumes are associated with improvements in quality (Ross et al., 2010). However, many believe that CON "...may have negative implications toward the provision of quality," (Grabowski and Angelelli, 2004: p. 794). This is owing to the potential for decreased competition in constrained markets. In a quality study of Medicaid patients in nursing homes, Grabowski and Angelelli

(2004: p. 810) found "...strong evidence that a repeal of CON and moratorium policies would encourage greater quality competition for the care of Medicaid residents in the most restrictive markets."

Research related to cost and access appears to be equally mixed. Steen (1997) discussed the findings of an Alpha Center study which found that CON had little measurable effect on reducing costs, however was beneficial for maintaining access for underserved populations and promoting better quality. In addition, a study conducted by Georgia State University examined 37 papers examining CON and concluded with this statement: "Our review of the research literature indicates that Certificate of Need programs have not only failed to achieve lower hospital costs, but they may have contributed to higher costs, greater inefficiency and lower quality of care. Although there have been no major studies of CON laws in the last five years, the evolution of the healthcare delivery system has removed much of the rationale for these programs' existence," (Steen, 1997). Perhaps, this is why in their study of new hospital orthopaedic surgery programs, Lu et al. (2010) found that utilization of services is similar in markets with and without new programs. Given these findings, it is not surprising that advocates exist on both sides of the CON debate (see AHPA, 2004a; 2004b for detailed descriptions of the positions for and against CON legislation[2]).

In sum, it appears that a lack of empirical evidence is available to inform the CON debate with regard to some of the key consequences of the legislation. At minimum, the extant research appears to have produced mixed findings. Therefore, the aim of this study is to inform the curiosity that exists with regard to key consequences of CON legislation. This aim is fulfilled by examining key differences between CON and non-CON states, with a particular interest in states that enforced CON for acute hospital beds in 2010. This analysis is framed around three important research questions. *First, how, if at all, do CON and non-CON states differ? Second, how, if at all, does hospital performance differ in CON and non-CON states? Finally, how, if at all, is the healthcare experience (cost and access) different for residents in CON and non-CON states?* These findings provide important insights for policy makers, healthcare executives, patient advocates, and others interested in healthcare delivery.

Methodology

Data sources

Data were retrieved from three publicly available secondary sources; the American Hospital Directory (AHD), the United States Census Bureau (Census Bureau), and the AHPA. The data fields extracted from the AHD database were: 1) state, 2) hospitals by state, 3) beds by state, 4) discharges by state, 5) patient days by state, and 6) gross patient revenue by state. The AHD collects data from a number of sources in developing its hospital profiles. According to the AHD, profile information is updated from several sources including DNV Hospital Accreditation status, Joint Commission accreditation status, National Provider Identifiers (NPIs) from latest NPPES data, contact information from SK&A, and Group Purchasing Organization (GPO) affiliations (see AHD, 2011). Cost data is sourced by AHD from CMS Cost Report data which is updated quarterly. At the time of this data extraction, the data was current up to the quarter

[2] The American Health Planning Association (AHPA) is a non-profit membership organization committed to health policies and the creation of health service systems that promote quality, assure equal access, and advocate reasonable costs.Through its newsletter, web site, educational endeavors, and research projects, AHPA supports its members and the healthcare community (see http://www.ahpanet.org/index.html for more information).

ending June 30, 2011. The most recent cost reporting periods for active hospitals at the time of data collection are reported in table 3. It should be noted that the vast majority of hospitals in the dataset (5,340 or 78.8%) have reported from 2010 period.

Table 3. CMS Cost report data – hospital reporting periods by year (from AHD, 2011).

Fiscal year	Number of hospitals reporting
2011	6
2010	5,340
2009	694
2008	25
2007	12
<2007	12
N/A	685

The data fields extracted from the Census Bureau were limited to the reported population by state in the 2010 U.S. Census report for the year 2010 (Mackun and Wilson, 2011). The data fields extracted from the AHPA were limited to an identification of states possessing CON for acute hospital beds during 2010 (AHPA, 2011). Careful attention was paid to make every effort to ensure that data from all three publically available secondary sources correspond to a common period (2010). Following collection, the data from these three sources were aggregated into a dataset for analysis.

Data analysis

Key variables of interest were directly collected in the datasets or computed in an effort to examine the three research questions identified earlier. The variables employed to examine research question 1 (*How, if at all, do CON and non-CON states differ?*) are state population (POP), the number of hospitals per state (HPS), beds per state (BPS), discharges per state (DPS), and gross patient revenue per state (RPS). The variables employed to examine research question 2 (*How, if at all, does hospital performance differ in CON and non-CON states?*) are beds per hospital (BPH), revenue per hospital (RPH), and discharges per hospital (DPH). Finally, the variables employed to examine research question 3 (*How, if at all, is the healthcare experience (cost and access) different for residents in CON and non-CON states?*) are revenue per state population (RPP), discharges per state population (DPP), and state population per hospital (PPH). The variables were selected and/or computed as proxy measures for key outcomes of interest. See table 4.

Table 4. Variables as proxy measures

Variable	Proxy measure
State population (POP)	State level demand size in terms of population
Hospitals per state (HPS)	State level healthcare capacity
Beds per state (BPS)	State level healthcare capacity
Discharges per state (DPS)	State level volume activity (or throughput)
Gross patient revenue per state (RPS)	State level healthcare spend
Beds per hospital (BPH)	Hospital level size (capacity)
Revenue per hospital (RHP)	Hospital level financial performance (gross)
Discharges per hospital (DPH)	Hospital level volume activity (or throughput)
Revenue per state population (RPP)	Resident level healthcare spend
Discharges per state population (DPP)	Resident level utilization
State population per hospital (PPH)	Resident level access to care (size of catchment area)

The dataset was analyzed using IBM SPSS version 19. Descriptive statistics were calculated for each of the key variables under study. Table 5 displays the mean, standard deviation, kurtosis and skewness statistics for each variable. The means represents the average value for each variable, while the standard deviation provides a measure of spread in the data distribution. Kurtosis and skewness test the normality of the data distribution for each variable in terms of peakedness/flatness and symmetry around the mean respectively (Hair et al., 2006). With regard to kurtosis, Kline (2011: p. 63) suggests that "...absolute values from about 8.0 to over 20.0 of this index are described as indicating 'extreme' kurtosis. A conservative rule of thumb, then, seems to be that absolute values of [kurtosis index] KI > 10.0 suggest a problem, and absolute values of KI > 20.0 indicate a more serious one." The KI value for state population (POP) is the highest of the variables in the study (9.05). While this value is of some concern to the researcher, it is below the 10.0 threshold described by Kline (2011), and thus kurtosis is dismissed as potentially problematic in the data[3].

Each variable was also tested for skewness. With regard to skewness, values extending outside of the range of – 1 to + 1 indicate a potentially skewed distribution (Hair et al., 2006). A number of the variables under study display skewness values greater than + 1, indicating that the data distribution is skewed to the right (positive) for these variables. These variables are denoted in italics in table 5. Data transformations provide a procedural remedy in such situations. Specifically, the logarithm often provides an adequate treatment for normalizing data in distributions demonstrating positive skewness (Hair et al., 2006). Therefore, the logarithm (log) was computed for state population (POP), hospitals per state (HPS), beds per state (BPS), discharges per state (DPS), gross patient revenue per state (RPS), and revenue per hospital (RPH). All of the newly computed variables (e.g., log of *variable name*) produced acceptable values for kurtosis and skewness and were therefore used in subsequent analysis.

[3] The log of state population was used in subsequent analysis given the high skewness value. Thus, the kurtosis value was subsequently immaterial during data analysis.

Table 5. Descriptive statistics

Variable	μ	σ	Kurtosis†	Skewness†
State population (in 000s) (POP)	6009.06	6,764.45	*9.05*	*2.69*
Log of state population (in 000s) (LOGPOP)	8.21	1.03	-0.55	-0.06
Hospitals per state (HPS)	77.88	76.68	6.14	*2.25*
Log of hospitals per state (LOGHPS)	3.93	0.97	-0.51	-0.22
Beds per state (BPS)	14,620.23	16,063.50	4.35	*2.08*
Log of beds per state (LOGBPS)	9.06	1.09	-0.57	-0.14
Discharges per state (DPS)	631,596.79	684,750.21	4.16	*2.01*
Log of discharges per state (LOGDPS)	12.81	1.13	-0.58	-0.24
Gross patient revenue per state (in 000s) (RPS)	38,483,079.42	49,053,858.44	7.54	*2.54*
Log of gross patient revenue per state (in 000s) (LOGRPS)	16.81	1.20	-0.71	0.00
Beds per hospital (BPH)	175.8	53.1	1.13	0.75
Revenue per hospital (in 000s) (RHP)	436,577.62	200,459.27	2.13	*1.06*
Log of revenue per hospital (in 000s) (LOGRHP)	12.88	0.49	1.56	-0.72
Discharges per hospital (DPH)	7,646.78	2,757.56	0.38	0.59
Revenue per state population (RPP)	5,768.37	1,844.76	2.60	0.70
Discharges per state population (in 000s) (DPP)	102.09	23.67	2.75	0.63
State population per hospital (in 000s) (PPH)	75.53	22.40	-0.81	-0.71

† Variables demonstrating potentially problematic kurtosis and/or skewness values are identified in italics. Logarithmic transformations were produced for these variables with the results reported directly below each non-normal variable.

Results

The sample of 52 states was next bifurcate into two subsamples; one containing states which employed CON for acute hospital beds in 2010 (n=28) and a second subsample of those states which did not (n=24). T-tests were employed to examine differences between the two groups (CON states and non-CON states). T-tests are a statistical procedure commonly used to assess differences between group or sample means (see Hair et al., 2006; Hong et al., 2010; Dobrzykowski, 2012). The results of the t-tests are displayed in table 6.

Table 6. T-test results for examining mean differences between CON and non-CON states

Variable	CON n=28	Non-CON n=24	T-value	Groups are different?
Log of state population (in 000s) (LOGPOP)	5,625.8	6,456.2	-0.12 *n/s*	No
Log of hospitals per state (LOGHPS)	69.2	88.0	-0.82 *n/s*	No
Log of beds per state (LOGBPS)	14,694.5	14,533.6	0.16 *n/s*	No
Log of discharges per state (LOGDPS)	622,815.1	641,842.1	0.13 *n/s*	No
Log of gross patient revenue per state (in 000s) (LOGRPS)	36,376,596.1	40,940,643.3	0.37 *n/s*	No
Beds per hospital (BPH)	198.8	149.0	3.79***	Yes
Log of revenue per hospital (in 000s) (LOGRHP)	496,072.6	367,166.9	2.67***	Yes
Discharges per hospital (DPH)	8,606.5	6,527.1	2.90***	Yes
Revenue per state population (RPP)	6,121.3	5,356.7	1.51 *n/s*	No
Discharges per state population (DPP)	0.11	0.10	1.47 *n/s*	No
State population per hospital (PPH) (in 000s)	81.6	68.5	2.17**	Yes

***significant at $p < 0.01$; **significant at $p < 0.05$; *n/s* not significant.

Notes:

1) Variable means for the original variables (non-logarithmic means) are provided to display the difference between groups.
2) T-tests examined logarithmic transformations when necessary due to non-normality to determine statistical differences between the groups (variables indicated by Log of…). Variables that were not transformed satisfied normality tests.

The results reveal that the mean population in CON states (5,625,800) is not statistically different from the mean population in non-CON states (6,456,200). Likewise, the mean number of hospitals in CON states (69.2) is not statistically different than the mean number of hospitals in non-CON states (88.0). The mean number of acute hospital beds in CON states (14,694.5) is not statistically different than the mean number of acute hospital beds in non-CON states (14,533.6). The mean number of discharges in CON states (622,815.1) is not statistically different than the mean number of discharges in non-CON states (641,842.1). The mean gross patient revenue in CON states ($36,376,596,100) is not statistically different than the mean gross patient revenue in non-CON states ($40,940,643,300). The mean number of beds per hospital in CON states (198.8) is statistically different (higher) than the mean number of beds per hospital in non-CON states (149.0). Similarly, the mean revenue per hospital in CON states ($496,072,600) is statistically different (higher) than the mean revenue per hospital in non-CON states ($367,166,900). The mean number of annual discharges per hospital in CON states (8,606.5) is statistically different (higher) than the mean number of annual discharges per hospital in non-CON states (6,527.1). The mean patient revenue per population in CON states ($6,121.3) is not statistically different than the mean patient revenue per population in non-CON states ($5,356.7). The mean discharges per population in CON states (0.11) is not statistically different than the mean discharges per population in non-CON states (0.10). Finally, the mean state population per hospital in CON states (81,600) is statistically different (higher) than the mean state population per hospital in non-CON states (68,500).

Discussion

CON regulation has been the topic of some debate, fueled by sparse, yet mixed empirical results from researchers. This study set out to inform curiosity regarding some key consequences of CON regulation. In doing so, this study framed three important research questions capable of providing insights at the state level, the hospital level, and individual resident level. Data were collected and analyzed from three publicly available secondary sources; the American Hospital Directory, the United States Census Bureau, and the American Health Planning Association to address the research questions under study.

First, how, if at all, do CON and non-CON states differ? Five variables were selected to assess CON and non-CON states for differences in terms of demand (measured by state population), capacity (measured by the number of hospitals per state, and beds per state), volume activity or throughput (measured by discharges per state), and healthcare spend/cost (measured by gross patient revenue per state). These variables were provided in table 4. The results reveal that statistically speaking, CON and non-CON states do not differ on any of these measures. While on the face, non-CON states have more residents, more hospitals, more discharges, and higher aggregate healthcare spend, they ironically have fewer beds than CON states. Although these results may appear mixed, statistically these findings suggest that CON does not influence demand, capacity, volume activity or throughput, or healthcare spend/cost at the state level.

Second, how, if at all, does hospital performance differ in CON and non-CON states? Three variables were selected to examine differences in hospital performance between hospitals operating in CON states and those operating in the absence of CON laws. These variables assessed hospital size or capacity (measured by the number of beds per hospital), hospital volume activity or throughput (measured by discharges per hospital), and hospital financial performance (measured by revenue per hospital). These results suggest that hospitals operating

in CON states are statistically different from hospitals operating in non-CON states on all three measures. Specifically, hospitals in CON states are nearly 50 beds (or approximately 33%) larger than hospitals in non-CON states. This supports the notion that when hospitals in CON states are awarded a certificate, they are likely to build larger facilities than their counter parts in non-CON states. This larger capacity appears to perhaps enable higher levels of volume activity or throughput, as hospitals in CON states generate more than 2,000 additional annual discharges than their non-CON counterparts. This is a likely contributor to the higher financial performance enjoyed by hospitals in CON states. These findings suggest that hospitals located in CON states generate nearly $130,000,000 (or approximately 35%) more annual revenue than hospitals in non-CON states. Thus, statistically these findings suggest that CON regulation does positively influence size or capacity, volume activity or throughput, and financial performance at the hospital level.

Finally, how, if at all, is the healthcare experience (cost and access) different for residents in CON and non-CON states? Three variables were selected to examine differences in cost and access for residents residing in CON states and those residing in non-CON states. These variables assessed healthcare cost (measured by revenue per state population), utilization (measured by discharges per state population), and access to care (measured by state population per hospital) at the individual resident level. This study finds that, statistically, residents in CON states do not differ from residents in non-CON states in terms of annual healthcare spend and utilization. While the difference is not statistically significant, it is interesting to note that residents in non-CON states actually spend less annually on healthcare per resident (approximately $5,367) than do residents of CON states (approximately $6,121). A statistically significant difference is found when considering access to care for residents in CON versus non-CON states. This study finds that residents in CON states access care in hospitals with substantially larger catchment areas (approximately 81,600 residents) as compared to catchment areas of 68,500 residents in non-CON states. Therefore, while cost and utilization appear to be statistically the same for residents in CON and non-CON states, access to care is more constrained in CON states.

Conclusions

Taken together, the findings from this study should be of interest to policy makers, hospital executives, and patient advocates interested in the effectiveness of CON in managing key outcomes of the healthcare delivery system; namely quality, cost, and access. These findings suggest that CON does not appear to have a substantial effect at the state level in managing demand, capacity, volume activity or throughput, or healthcare spend/cost. At the same time for hospitals, these results show that facilities in CON states enjoy larger size or capacity, higher volume activity or throughput, and better financial performance than hospitals in non-CON states. For residents, while cost and utilization appear to be statistically the same regardless of their state's CON status, access to care may be more constrained for residents in CON states. While the evidence found herein for increased hospital volume associated with CON may support the claims of Ross et al. (2010) linking volume and quality, these findings appear to provide support for additional evaluation and rethinking of the role of CON in balancing quality, cost, and access (Langley et al., 2010).

Limitations of the study

While this study is useful in informing curiosity regarding some key consequences of CON regulation, it is not without limitations and/or shortcomings. For example, although the data analyzed herein was collected from well-respected public sources, the author is unable to make any judgment as to the validity of the data. This is a common challenged faced by researchers, particularly when using secondary data. As Langley et al. (2010) observed in their CON study, even population projections can differ substantially when analyzed from multiple sources. With regard to the present study, while a reasonable attempt was made to ensure that all of the data collected and analyzed were from corresponding time periods, it should be qualified that only 78.8% of the hospital cost data was retrieved for the same period as the Census and CON data (2010). Finally, some of the data analyzed in this study demonstrates non-normal distribution characteristics. While reasonable attempts have been made to remedy this potential problem through the use of logarithmic transformations (Hair et al., 2006), it is worthy to note as a possible limitation.

Next, the aim of this study was to conduct a cross-sectional investigation into the effects of CON regulation by analyzing data from all of the states in the U.S.A. While this aim was achieved, it is worthy to note that states differ in a variety ways that could not be controlled for in this study. First, the implementation of CON regulation, even with regard to the narrow scope of acute hospital beds, varies from state to state. For instance, states such as Illinois, New York, Iowa, and Michigan have all implemented CON laws to govern inpatient bed need, however, the methodology for calculating bed need differs substantially (see Chapter 203, 1987; Part 709…, 1993; Illinois Health…, 2010; Langley et al., 2010). In a similar fashion, the cross-sectional data analyzed in the course of this study was captured as a snap shot in time and does not control for the maturity of a particular state's CON program. Finally, states may also differ in terms of the health status of their residents. Given that health status is suggested to influence utilization, another limitation of this study exists in that it does not control for health status in the cross-sectional data analysis.

References

American Health Planning Association (AHPA). (2011). *National Directory: State Certificate of Nee Programs Health Planning Agencies 2011*. Retrieved on December 27, 2011 at http://www.ahpanet.org/matrix_copn.html

American Health Planning Association (AHPA). (2004a). Improving Healthcare: A Dose of Competition AHPA Response. Arguments in favor of planning and CON regulation. Retrieved on January 2, 2012 from http://www.ahpanet.org/files/AHPAargfavorCON.pdf

American Health Planning Association (AHPA). (2004b). Improving Healthcare: A Dose of Competition AHPA Response. Arguments against FTC assertions and assumptions. Retrieved on January 2, 2012 from http://www.ahpanet.org/files/AHPAargagainstFTC.pdf

American Hospital Directory (AHD) (2011). Definitions and Methodology. Retrieved on September 14, 2011 at http://www.ahd.com/definitions/statistics.html.

Chapter 203: Standards for Certificate of Need Review. (1987). Retrieved on January 2, 2012 at http://www.legis.state.ia.us/Rules/Current/iac/641iac/641203/641203.pdf

Dobrzykowski, D. (2012). Examining heterogeneous patterns of Electronic Health Records Use: A contingency perspective and assessment. *International Journal of Healthcare Information Systems and Informatics,* 7(2), 1-16.

Grabowski, D.C. and Angelelli, J.J. (2004). The relationship of Medicaid payment rates, bed constraint policies, and risk-adjusted pressure ulcers. *Health Service Research,* 39(4), part I, 793-812.

Hair, J., Black, W., Babin, B., Anderson, R., and Tatham, R. (2006), *Multivariate Data Analysis, Sixth edition,* Pearson Prentice Hall, Upper Saddle River, New Jersey.

Hong, P., Dobrzykowski, D. and Vonderembse, M. (2010). Integration of supply chain IT and lean practices for mass customization: benchmarking of product and service focused manufacturers. *Benchmarking: An International Journal, 17*(4), 561-592.

Illinois Health Care Facilities Plan: Narrative and Planning Policies: Medical-Surgical Care and Pediatric Care (2010). Amended at 34 Ill. Reg. 6067, effective April 13, 2010. Retrieved on January 2, 2012 at http://www.ilga.gov/commission/jcar/admincode/077/077011000D05200R.html

Kline, R. B. (2011). *Principles and Practice of Structural Equation Modeling, Third Edition.* New York, NK: Guilford Press.

Langley, S.A., Fuller, S.P., Messina, J.P., Shortridge, A.M., and Grady, S.C. (2010). A methodology for projecting hospital bed need: a Michigan case study. *Source Code for Biology and Medicine*, 5(4), 1-10.

Lu, X., Hagen, T.P., Vaughan-Sarrazin, M.S., and Cram, P. (2010). The impact of new hospital orthopaedic surgery programs on total joint arthroplasty utilization. *The Journal of Bone and Joint Surgery,* 92, 1353-1361.

Mackun, P. and Wilson, S. (2011). Population distribution and change: 2000 to 2010. *2010 Census Briefs,* C2010BR-01, March 2011, 2 pages.

Madden, C.W. (1999). Excess capacity: markets, regulation, and values. *Health Services Research,* 33(6), 1651-1668.

Part 709 Determination of Public Need for Medical Facility Construction. (1993). Retrieved on January 2, 2012 from http://www.health.ny.gov/nysdoh/rules/709.htm

Ross, J.S., Normand, S.T., Wang, Y., Ko, D.T., Chen, J., Drye, E.E., Keenan, P.S., Lichtman, J.H., Bueno, H., Schreiner, B.S., and Krumholz, H.M. (2010). Hospital volume and 30-day mortality for three common medical conditions. *New England Journal of Medicine,* 362(12), 1110-1118.

Steen, J. (1997). Certificate of Need: A review. *American Health Planning Association.* Retrieved on December 20, 2011 at http://www.ahpanet.org/files/CON%20A%20REVIEW.pdf

About the author

David D. Dobrzykowski was an Assistant Professor of Operations and Supply Chain Management in the Department of Computer Information Systems in the College of Business at Eastern Michigan University (USA) when this white paper was completed. On July 1, 2012, Dr. Dobrzykowski joined the University of Toledo (UT) as Director for the School of Healthcare Business Innovation and Excellence. He also serves in a joint faculty appointment as an Assistant Professor of Information Operations and Technology Management in UT's College of Business and Innovation and an Assistant Professor of Public Health and Preventive Medicine in UT's College of Medicine and Life Sciences. He holds a Ph.D. in Manufacturing and Technology Management as well as BBA and (E)MBA degrees from the College of Business at UT. He also earned a graduate certificate in Public Health Epidemiology from UT's College of Medicine. Prior to his Ph.D., Dr. Dobrzykowski enjoyed a 13 year career as a healthcare executive, holding titles such as Chief Executive Officer and Vice President in the provider and insurance verticals of the healthcare sector. His research interests include operations and supply chain management, and information technology, specifically related to the application of these concepts for value co-creation in healthcare (service-dominant logic). His research has been published (or is forthcoming) in journals and books including *Decision Sciences Journal of Innovative Education, Benchmarking: An International Journal, International Journal of Healthcare Information Systems and Informatics, International Journal of Information Security and Privacy, International Journal of Information Systems and Change Management, International Journal of Procurement Management, International Journal of Services and Operations Management, Pervasive Information Security and Privacy Developments: Trends and Advancements, Service Science,* and *Strategic Outsourcing: An International Journal.* Dr. Dobrzykowski can be contacted at (419) 297-6600 or david.dobrzykowski@utoledo.edu.

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Projected Economic Impact from Construction
New Hospital - Clarkston, Michigan

Total Project Cost		$300,000,000
Client-direct or Soft (as % of Project)	33%	$99,990,000
Construction Cost		$200,010,000
Indirect (CM) costs (as % of Construction)	15%	$45,000,000
Direct Trade Costs		$155,010,000
Portion Spent on Labor	50%	$77,505,000

Direct Wages		
Work Year (hours)	1,860	
Wages (Hourly; Annual)	35	65,100
Trade Contractor Direct Costs		
Labor Burden	35%	22,785
Trade Contractor Indirect Costs		
OH&P	12%	10,546
Small Tools	4%	3,515
Equip	10%	8,789
Total project cost per FTE (Rounded)		110,700
Total Jobs Created (FTEs, rounded)		700
Duration of Project (years)	3.0	
Jobs Per Year		233

"Plugs" for other jobs created		
Owner/PM/Developer - FTEs (for duration)	12	
Design - FTEs (short term)	30	
CM/GC - FTEs (for duration)	15	
Total Jobs Created (FTEs, rounded)		757

'The closer'

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McLaren CEO Phil Incarnati is the force and face behind Michigan's fastest-growing health system. Can he get a new hospital built in Oakland County?

RYAN GARZA

A GROWING SYSTEM

Hospitals owned by **McLaren Health Care Corp.**:

- **McLaren-Bay Region**, Bay City, 404 beds
- **McLaren-Flint**, 378 beds
- **McLaren-Oakland**, Pontiac, 335 beds
- **McLaren-Greater Lansing**, 310 beds
- **McLaren-Macomb**, Mt. Clemens, 288 beds
- **McLaren-Lapeer Region**, 222 beds
- **McLaren-Northern Michigan**, Petoskey, 202 beds
- **McLaren-Central Michigan**, Mt. Pleasant, 118 beds
- **McLaren Orthopedic Hospital**, Lansing, 79 beds
- **McLaren-Bay Special Care**, Bay City, 31 beds

Source: McLaren Health Care

Phil Incarnati hasn't needed a PowerPoint presentation or slew of executive assistants to sell his affiliation proposals to any of the 10 hospitals or medical groups that have joined nonprofit **McLaren Health Care Corp.** over the past 22 years. Data and personal salesmanship have closed the deals.

Those skills have made Flint-based McLaren the fastest-growing health system in Michigan and Incarnati the state's highest-paid nonprofit hospital executive.

But Incarnati might need more than his usual powers of persuasion to achieve his current goal: Win approval for a 200-bed hospital in north Oakland County's Independence Township. It doesn't appear the hospital can be built under current certificate of need regulations and most likely will need a legislative exemption to go forward.

Still, Incarnati, a former star college athlete who says he hates to lose, is determined to build a hospital in the growing Clarkston area, which generates 25,000 inpatient admissions at area hospitals annually and needs a closer hospital emergency department for its residents, he said. The nearest ER is about 18 minutes, or eight miles, away in Pontiac.

Incarnati's penchant for growth derives from a competitive nature -- he goes big-game hunting to relax -- but also from early job experiences at **Detroit Receiving Hospital** and the now-defunct **Horizon Health System** that led him to believe that the key to success for hospitals is building a large, diversified, integrated system that focuses on quality, sound management and economies of scale to reduce costs.

And so growth has been the goal since he became CEO of McLaren in 1989, when it was a single hospital in Flint: now the 378-bed **McLaren Regional Medical Center**.

"We saw great opportunities in 1990 to build the system along the I-75 and I-69 corridors," Incarnati said. "Mobile technology was just emerging, and there weren't any systems north of Detroit at the time."

McLaren's growth strategy

That vision has propelled Incarnati's -- and McLaren's -- strategy. Incarnati's first acquisition, in 1992, was **Lapeer Regional Medical Center**.

In January, McLaren acquired its 10th hospital, 202-bed **Northern Michigan Regional Hospital** in Petoskey. It plans to re-open the former **Cheboygan Memorial Hospital** as an outpatient center and emergency department within the next 30 days.

All of those acquisitions were done the same way: Incarnati showed up, usually alone, with a box of documents on the proposed deal developed by his research staff.

"When I go to pitch a hospital or physician group, it is just me. I always go first and last. They have to feel comfortable with me and vice versa," Incarnati said.

It's an approach that usually works.

"Phil is the closer," said Mark O'Halla, CEO of **McLaren-Macomb Hospital** in Mt. Clemens. "He has an ability to talk with people on their own terms. When McLaren says we will do something, we do it. Follow-through is important, and people see that."

McLaren acquired the former **Mt. Clemens Medical Center** in July 2006 to get its first toehold in Southeast Michigan.

After losing $70 million the previous four years, the 288-bed community hospital turned a $3.5 million profit in the first year under McLaren.

"Every hospital we have acquired (except **Central Michigan Community Hospital**, Mt. Pleasant) was struggling before we came in. Mt. Clemens was the worst one," said Incarnati, who spent every day at the hospital for three months until O'Halla took over as CEO on Dec. 27, 2006. "We thought we could turn it around in the first year, and we did so."

Despite the hospital's financial struggles, Ted Wahby, chairman of McLaren-Macomb, said several hospital systems wanted to purchase the hospital.

"(McLaren was) looking to get into the marketplace here and wanted to preserve and build on what we were doing here. Others wanted to consolidate services because we are all competing against each other," said Wahby, treasurer of Macomb County, who helped raise funding for the $15 million **Ted B. Wahby Cancer Center** at McLaren-Macomb.

Wahby said McLaren's size and ability to tap into economies of scale in purchasing, insurance and clinical programs also were huge selling points.

"The days of the small hospital surviving are limited. Phil did a heck of a job explaining how growing larger as a system will help all hospitals," Wahby said. "There wouldn't have been a merger without Phil."

Over the next few years, the health system plans to nearly double in size.

"A few years ago, we thought to get sufficient size for economies of scale you had to be $2 billion to $3 billion in (net) revenue. Now, a system needs to have $4 billion to $6 billion in revenue," Incarnati said.

In 2011, McLaren reported $2.1 billion in annual net revenue and a 4 percent operating margin. For fiscal 2012 ending Sept. 30, McLaren is projecting $60 million in net operating income and $90 million in net income, which includes investment income.

McLaren has increased revenue an average of 20 percent annually for the past two decades, primarily by acquiring troubled hospitals and turning them around.

But Incarnati acknowledges that McLaren can't double in size by acquiring hospitals in Michigan alone.

"We are looking in Ohio and Indiana, and maybe Illinois," he said.

McLaren currently is talking with two hospitals in Indiana and one in Ohio. The company declined to name the hospitals because of confidentiality agreements.

"I won't do a deal in either state unless I can get $1 billion in business. You need size to make integration work," Incarnati said.

Growing up

Incarnati, 58, has had a competitive edge most of his life.

He grew up on the east side of Detroit and Warren with a passion for sports, fishing and hunting, a happy middle child between sisters Cindy and Kristen.

His mother, Lola, was a bindery worker. Father Donald worked 45 years for Chrysler and was a UAW chief steward.

"My dad calls me a pencil pusher," Incarnati said.

He studied pre-engineering and played football at the now-closed Warren Woods High School. In 1972, he won a scholarship to play strong safety at **Eastern Michigan University**, where he earned a bachelor's degree in management in 1976 and master's in business administration in 1982.

"I was the first in my family to go to college. I was going to be an electrical engineer, but I lost interest in math and science. In the second semester, I decided to pursue the business route," said Incarnati, who became chairman of the EMU board from 1995 to 2005, serving a total of 19 years on the board before leaving in 2010.

After college, Incarnati wasn't sure what field to pursue. But he knew a friend who worked at what was then Pontiac Osteopathic Hospital -- now owned by McLaren as **McLaren-Oakland** -- under then-CEO Patrick

Lamberti, and applied for a job in 1976.

"I didn't get it because I didn't have an MBA," Incarnati said. "I decided to get an MBA and go into health care."

In 1977, Incarnati was hired at the former Detroit General Hospital, which later became **Detroit Receiving Hospital**. He later worked at **Wayne State University School of Medicine** to help former Dean Robert Coye, M.D., begin development of the school's faculty practice plan.

While Incarnati took night classes for his MBA from 1979 to 1982, he worked for two years running the **University Health Center**, the ambulatory division of Detroit Receiving, now part of **Vanguard Health System Inc.**'s **Detroit Medical Center**.

While there, Incarnati learned under the tutelage of Cliff Gardner, Ed Thomas and the late John Danielson. Danielson was CEO of Detroit Receiving from 1979 to 1984; Gardner, who was treasurer in 1975-76 of **Blue Cross Blue Shield of Michigan**, was CFO; and Thomas was president.

"I met Phil when I became president of Detroit Receiving in 1981," said Thomas, who retired in 1994 and is chairman of **Health Centers Detroit Foundation**, which operates two federally qualified health centers in Detroit and one in Southfield.

"I quickly identified Phil as a bright, intelligent and committed individual. I put him in challenging positions, and he responded very well," said Thomas, a former chairman of the **Michigan Health and Hospitals Association**.

Incarnati said he reluctantly accepted a promotion from Thomas that later paid off.

"Ed forced me to do something in my career I didn't want to do. He wanted me to move to the inpatient side. He forced me to do it," Incarnati said, noting that he preferred the ability that ambulatory care provided to work directly with doctors.

But within a year in 1982, Incarnati became CEO of his first hospital, the former **Detroit Osteopathic Hospital**, which was owned by Horizon in Detroit. Horizon was later acquired by Detroit-based **Henry Ford Health System**.

"It helped my career," he said. "The hospital later closed down, but I was promoted to COO in 1984. My job was to get rid of two Western hospitals in California, in the Watts neighborhood of Los Angeles, and another in Seattle."

RYAN GARZA

Finding Independence

Incarnati's early 2006 negotiation toward a non-ownership agreement with **Clarkston Medical Group**, a primary care practice with 22 physicians and physician assistants, led to the plan for an Independence Township hospital.

James O'Neill, M.D., head of the group, said he had unsuccessfully approached Royal Oak-based **Beaumont Hospital** and **St. Joseph Mercy Oakland Hospital** in Pontiac about the group's interest in building a new hospital in the Clarkston area.

"Beaumont did not want to build a complete hospital with cardiac care, pediatrics and obstetrics," O'Neill said. "St. Joseph's wasn't interested."

At a **Big Boy** restaurant in Clarkston in early 2006, O'Neill asked Incarnati for his strategic vision in

Incarnati is looking to expand McLaren into neighboring states — if the numbers add up. "I won't do a deal in either state unless I can get $1 billion in business," he said.

O'Neill asked Incarnati for his strategic vision in Southeast Michigan. On a napkin, Incarnati drew up his plan for a medical center and hospital in Independence Township.

"Phil is a go-to guy with impeccable integrity. It didn't take us more than 90 minutes" to reach agreement on the plan," said O'Neill, a pediatrician who founded the Clarkston Medical Group 52 years ago.

After six years of planning, McLaren in early February filed a certificate of need application to build the 200-bed hospital in Independence Township for about $308 million.

O'Neill said he was impressed with Incarnati's glitz-free sales approach.

"Phil is very innovative, a straightforward person who works very well with people. I felt he would do a very good job in putting a hospital here," O'Neill said.

If state approval is granted either by permit or legislation, the hospital will be at the 80-acre **McLaren Health Care Village**. On the site is Clarkston Medical Group, which owns 10 acres and a 140,000-square-foot clinic that opened in 2008.

McLaren leases space in the Clarkston clinic for a 17,000-square-foot surgery center, which is a joint venture among McLaren; **United Surgical Partner Inc.**, Dallas; and a group of surgeons. McLaren also operates a 32,000-square-foot satellite facility there for its **Great Lakes Cancer Institute**.

While the Clarkston Medical Group remains independent, the group's future is now linked to McLaren, O'Neill said.

At peak for pay

McLaren's rapid growth also has led to Incarnati being the highest-paid nonprofit hospital CEO in Michigan.

In 2011, Incarnati had total compensation of $6.194 million, a 1.4 percent increase from $6.185 million in 2010. In 2009, though, his compensation was $15.1 million, which included a one-time pension payout of $12.3 million when he turned 55.

While 2011 compensation data was unavailable for other CEOs in Southeast Michigan, in 2010 CEO Nancy Schlichting of Henry Ford Health System earned $2.1 million, including a pension payout of $424,522; CEO Mike Duggan of DMC earned $2 million, including a pension payout of $17,075; and CEO Brian Connelly of Oakwood Healthcare earned $1.7 million, including a pension payout of $307,392.

The discrepancy between Incarnati's pay and the pay of top executives at much larger health systems has led to some behind-the-scenes criticism, but Incarnati said he is one of the longest-tenured CEOs in the nation at 23 years.

"I don't decide what I make. Our compensation committee decides it, and half my income is at risk every year," Incarnati said.

A statement from McLaren said that 50 percent of Incarnati's "annual cash compensation is at risk based totally on performance tied to achievement of specific financial and clinical quality goals."

Several competing hospital executives declined interviews about Incarnati, McLaren and plans to build a new hospital in Clarkston. They include Gene Michalski of **Beaumont Health System**; Mike Duggan of Detroit Medical Center and Elizabeth Aderholdt of **Genesys Health System** in Flint.

Oliver Jurkovic, partner in health and human services with Southfield-based **Plante Moran Financial Advisors**, said Incarnati takes more of a business approach to managing hospitals than most executives.

"He has a keen eye when looking at the whole environment with mergers and acquisitions," said Jurkovic, who is Plante Moran's lead partner with the McLaren account. "He has a good sense of what an underperforming asset is and how a system like McLaren can assist community hospitals to become thriving entities."

Ron Irwin, M.D., a former Beaumont chief medical officer and now McLaren's director of oncology services, said physicians respect Incarnati because he knows when something can or can't be done.

"I have dealt with administrators my whole life. Phil is more like a surgeon. He analyzes a problem, does due diligence, makes a decision and then it is done," said Irwin, an orthopedic oncologist based at McLaren-Macomb.

"Some administrators will give you the slow no -- they nod their head while you're talking, leaving you thinking you had a deal," Irwin said. "Then, slowly but eventually, you'd realize that they never had any intention of doing the deal. Phil isn't like that at all. What he says, you can take to the bank."

Out for bigger game

Since his youth, Incarnati has pursued his love of bird hunting, fishing and sports.

But big game hunting is something he took up just 10 years ago.

"There is a certain excitement and exhilaration that goes with hunting dangerous game," said Incarnati. "It is about confidence, planning and reliance on the team to get something done. It emerged first with athletics, my corporate days, and now this."

Last year, Incarnati and his wife, Laurie, took a hunting trip to the Limpopo Province, four hours north of Johannesburg, South Africa. He shot a male lion and a cape buffalo. She shot a blesbok, a type of antelope.

"I went to dinner with Phil and Laurie last year, and he was so excited about his safari in Africa," said Jim Stapleton, who served with Incarnati on the EMU board of regents and is president of Ann Arbor-based **B & R Consultants Inc.** "He showed me all these pictures on his iPad of the animals he killed in the wild. Hunting is an absolute relief for him."

Incarnati said he is running out of space at home for the animals he has killed, stuffed and mounted.

"In January, I bagged a mountain lion in Idaho, a nice tom," he said.

Besides hunting, Incarnati enjoys golfing with friends, co-workers, physicians and clients.

"Nobody is trying to make the senior tour," Stapleton said. "Phil is calm, measured, always focused but pleasant. But he likes to win. This is a guy who ultimately has won at everything he does."

Stapleton particularly remembers one golf outing with Incarnati.

"I had him out to my club two years ago to meet with Ron English, the new Eastern football coach. We played nine holes, and Phil shot a 36. He had a career day. He is not that good (ordinarily)," Stapleton said.

O'Halla said Incarnati is competitive and supportive on the golf course, depending on the situation.

"When we play golf, there is always a bet going on. Not for much," O'Halla said. "If you make a bad shot, he will rib you. But if you are his partner, he won't get on you too much. We spend so much time working, it is good to relax."

Incarnati said golfing is about camaraderie and competition.

"I don't like losing, never have," said Incarnati, who lamented his handicap is higher than he'd like at 11. "The true measure of the person is how they handle themselves when they lose."

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gongwer.com http://www.gongwer.com/programming/news.cfm?article_ID=511800102

Gongwer News Service

A bill that would make changes to the state's Certificate of Need policy dealing with hospitals that would in turn help McLaren Health Systems build a new hospital in Clarkston is expected to be introduced in the Senate on Tuesday when it returns to for a month of session days before Election Day.

Certificate of Need attempts to prevent overbuilding of hospital facilities, which can end up driving up the cost of health care, which is exactly what opponents to changing the policy argue with regard to the legislation expected to be introduced by Sen. Mike Kowall (R-White Lake Township).

"Certificate of Need began as a national health care cost-containment strategy to manage the glut of health care overbuild. Here in Michigan, it continues to be the most effective way to provide affordable and accessible medical care within reasonable geographic areas," Kelly Rossman-McKinney, spokesperson for proponents of Certificate of Need, said in a statement. "Without Certificate of Need, there could be competing services on every corner ... and no services in some parts of the state."

Ms. Rossman-McKinney represents Friends of Certificate of Need, a coalition of organizations ranging from businesses, hospitals, unions and other associations. The group has argued that eight hospitals are within a 30-minute drive of McLaren's proposed site and therefore the facility is not necessary.

But Jeff Timmer, speaking on behalf of McLaren, said emergency options only exist in Pontiac and Flint. McLaren's efforts have so far been rejected by the Certificate of Need Commission, pushing it to move toward legislative action.

That legislation is expected to be broad in detail and would try to address some practices that have caused worries in terms of overall treatments, Mr. Kowall said in a previous interview with Gongwer News Service (See Gongwer Michigan Report, August 13, 2012).

Mr. Kowall could not be reached Monday.

"The system that allows the building of hospitals hasn't kept pace with the growing of populations in the areas," Mr. Timmer said. "What McLaren has been looking at is building a 200-bed, $500 million facility in Clarkston that would employ a minimum of 1,300 full-time positions, maybe as many as 3,000 if demand grows as expected."

Mr. Timmer said McLaren has been evaluating the decision for several years. It would help to account for massive population losses at its McLaren-Oakland facility in Pontiac where he said an 80 percent vacancy currently exists. The health care provider would shift some of those beds to the potential Clarkston facility where, by contrast, the population has increased over the years.

"The plan ... keeps the Pontiac option open and it meets the demand in northwest Oakland County," Mr. Timmer said. "Studies have shown the Clarkston facility will

develop between $600 million and $800 million of economic activity annually."

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McLaren Oakland hospital needs legislation for expansion to Independence Township WITH VIDEO

By CHARLES CRUMMcharlie.crumm@oakpress.com; Twitter: @crummc

By CHARLES CRUMM
charlie.crumm@oakpress.com; Twitter: @crummc

A group that says it supports Michigan's process of siting hospitals is trying to head off legislation to allow McLaren Oakland in Pontiac to expand to Independence Township.

"We think it would certainly be bad for Pontiac," said Bret J. Jackson, president of the Economic Alliance for Michigan.

Jackson and others met with The Oakland Press Wednesday to detail objections to plans to shift 200 hospital beds from Pontiac to Independence Township, arguing the plan has already been rejected by the state commission that issues Certificates of Need to hospitals to allow them to locate new facilities.

The group argues there is an abundance of vacant hospital beds already in Oakland County, and that there are eight hospitals within a 30-minute drive of Clarkston, including McLaren in Pontiac.

They also say an expansion economically harms other surrounding hospitals by siphoning patients while leaving Pontiac in the lurch as jobs are shifted to another part of the county.

State Sen. Mike Kowall plans to introduce legislation by Sept. 11 that would allow McLaren to pursue its plans, and said he hopes the legislation gets a fair hearing.

"It's not going to interfere with the current day-to-day operations of McLaren in Pontiac," said Kowall, a White Lake Republican. "They have no desire to desert the city, they have no intentions of moving, no desire to move. They're an integral part of the city of Pontiac.

"That was one of the things I had to make sure of before I agreed to work with them," he said.

Hospitals have to apply for a Certificate of Need in order to build facilities with additional beds.
Continued...

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Kowall said the legislation he'll introduce will allow McLaren to proceed without gutting Michigan's Certificate of Need process.

"Hospitals have a love-hate relationship with Certificate of Need," Kowall said. "When they get everything they want, they love it. When they don't, they hate it.

"I'm not of the mindset that it would go away but I don't have a problem bending a piece of legislation

that's 50 years old to reflect a need in a certain area," Kowall said.

Jeff Timmer, of the Lansing-based Sterling Corp., represents a coalition that includes McLaren that is so new it doesn't have a name.

The goal of the legislation is to revamp the Certificate of Need system to allow hospitals to shift along with changes in population.

"The system doesn't allow the health-care facilities to shift with the population," Timmer said. "What that leads to is gluts of beds in some places and absence of beds in other places."

He said McLaren wants to invest up to $500 million and employ minimum of 1,400 people, including multiple years of construction jobs tied to an Independence Township facility near Clarkston.

"If demand goes where it looks like its going, we're talking 3,000 people that would be employed," he said.

He said there are no plans to close the Pontiac facility.

McLaren's plans also have the support of Oakland County's administration and Executive L. Brooks Patterson, who remains hospitalized for physical rehabilitation from injuries sustained in a two-car crash Aug. 10. Continued...

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"We absolutely support their establishment of additional beds in Independence Township," said Oakland County Chief Deputy Executive Gerald Poisson. "We think it means a lot of jobs in Oakland County and will help stabilize Pontiac because of the other uses McLaren has planned for the facility in Pontiac."

Poisson said a possible use is a nursing school as a medical school develops at Oakland University.

Patterson, 73, is recovering from his injuries at McLaren Oakland in Pontiac. He is on the Nov. 6 ballot for a sixth four-year term and faces Democrat Kevin Howley of Huntington Woods.

Howley, calling McLaren an "important part of the community," argues the McLaren plans would simply transfer jobs from one part of the county to another, rather than create additional jobs.

"But the Patterson administration keeps talking about adding 3,000 jobs and getting their friends in the Legislature to perpetuate that inaccuracy as well," Howley said. "Given the capacity issues, agreeing to transfer beds from Pontiac to a new facility in Clarkston sounds simpler than it is.

"A new facility would still add infrastructure costs to the system and, in turn, increase health care costs to users," Howley said. "Transferring beds also means you'll have empty parking lots, restaurants and gas stations in Pontiac as visitors go elsewhere."

Contact Charles Crumm at 248-745-4649, charlie.crumm@oakpress.com or follow him on Twitter @crummc and on Facebook. More information is at oaklandmichiganpolitics.blogspot.com. Keep up with the latest in local news by texting OPNews to 22700. ***Msg & Data Rates May Apply. Text***

McLaren to appeal state's rejection of bed transfer

Flint-based **McLaren Health Care** says it will appeal the state's denial of its certificate-of-need application to transfer 200 beds from its Pontiac hospital for a new hospital McLaren wants to build in Oakland County's Independence Township.

In February, McLaren filed a CON to relocate 200 of the 335 hospital beds at **McLaren Oakland** to the proposed hospital in Independence Township. McLaren planned to downsize its Pontiac hospital to 108 medical-surgical beds, plus 27 psychiatric beds with emergency care and surgical services.

But on June 25, the **Michigan Department of Community Health** denied McLaren's application, saying it failed to comply with the "replacement zone" requirement, which allows bed transfers only within two miles of the existing hospital. The proposed hospital is 7.6 miles from Pontiac, McLaren said.

In a statement to *Crain's* last week, McLaren said it has filed an administrative appeal. A hearing date was not scheduled as of press time.

"Continuing to operate under the current and archaic CON laws means that the only new hospitals ever built in the state of Michigan will have to be approved by the Legislature -- as was the case with both **Henry Ford Health System** and **Ascension Health** -- or the courts and not the CON Commission," said McLaren CEO Philip Incarnati in a statement.

"We are effectively frozen in time as decade-old CON laws prohibit innovation, stifle competition and deny health systems like McLaren the ability to respond to shifting populations and evolving markets," Incarnati said in the statement. "We can simply look forward to more new, overbuilt towers at existing locations located away from areas with population growth because that is the only permissible construction under the current CON standards."

McLaren operates 10 hospitals in Michigan, including two in Southeast Michigan.

Bret Jackson, president of the **Economic Alliance of Michigan**, a Novi-based business-labor coalition, said a hospital in the Clarkston area is unnecessary and would drive up costs for consumers and businesses.

"The CON Commission has a rigorous set of rules and guidelines that it reviews every three years, and it was just last year that the commission's Standard Advisory Committee reviewed the bed standard. McLaren's request, quite simply, did not meet the standard," Jackson said.

Earlier this year, McLaren began lobbying legislators to support its proposal to build the new hospital.

While no legislation has been drafted, McLaren officials have confirmed they have discussed the possibility with several Republican legislators.

The $308 million hospital would be on an 80-acre site that is part of the **McLaren Health Care Village of Clarkston**.

McLaren officials said they have documented a need for hospital services in northern Oakland County, citing increasing population, need for quicker ambulance rides in emergencies and community interest

as reasons.

But Jackson said there isn't a need for another hospital because the Clarkston area has six hospitals within 22 minutes with an average occupancy of 52 percent.

In 2002, **Henry Ford Health System** and **St. John Providence Health System** won special state legislative approval to transfer beds from existing hospitals to new hospitals in Oakland County.

In 2008, 200-bed St. John's **Providence Park Hospital** in Novi opened, followed by 300-bed **Henry Ford West Bloomfield Hospital** in 2009. St. Louis-based Ascension Health is the parent of St. John.

Jay Greene: (313) 446-0325, jgreene@crain.com. Twitter: @jaybgreene

O.C.A.T.S

Oakland County Association of Township Supervisors

President; *Thomas K Zoner, Supervisor Charter Township of Commerce*
2009 Township Dr
Commerce Twp., MI 49390
248-960-7070

August, 20, 2012

To whom it may concern

At a regular meeting of the OCATS on the members vote and passed unanimously to approve the resolution attached.

Thomas K. Zoner, President

Ayes
Addison Township
Bloomfield Township
Brandon Township
Commerce Township
Groveland Township
Highland Township
Holly Township
Independence Township
Lyon Township
Milford Township
Oakland Township
Orion Township
Oxford Township
Southfield Township
Springfield Township
Waterford Township
West Bloomfield Township
White Lake Township

Oakland County Association Township Supervisors

TITLE: A RESOLUTION OF SUPPORT BY THE OAKLAND COUNTY ASSOCIATION TOWNSHIP SUPERVISORS FOR THE CONSTRUCTION OF A 200-BED ACUTE CARE HOSPITAL LOCATED IN INDEPENDENCE TOWNSHIP, MICHIGAN BY MCLAREN HEALTH CARE CORPORATION.

WHEREAS: McLaren Health Care is a fully integrated Michigan-based health network, committed to quality, evidence-based patient care and cost efficiency;

AND

WHEREAS: McLaren has a broad footprint throughout the State of Michigan with a history of investing in communities through enhanced access to healthcare resources;

AND

WHEREAS: McLaren proposes to complete Phase Two of its Clarkston campus which serves northern Oakland county by constructing a 200-bed acute care hospital to meet growing demand in the area and alter its Pontiac campus by reducing the excess hospital bed capacity and adding an outstanding educational facility to the campus and making the Pontiac campus a cutting-edge provider of primary care;

AND

WHEREAS: The $300 million Clarkston Phase Two expansion will result in an increase in direct employment of 1,300, with an annual payroll of approximately $68 million, and an additional 250 construction jobs during the three-year period of construction;

AND

WHEREAS: McLaren estimates the multiplied economic effect of the Clarkston expansion to be 4,000 new jobs and $600-$800 million in annual economic impact;

AND

WHEREAS: The Independence Township Planning Commission and Board of Trustees has considered all comments and resolutions received during the public review and comment period, and McLaren has incorporated any necessary changes into the development plan amendment;

AND

WHEREAS: McLaren Health Care's plan to reallocate its hospital beds from its overcapacity Pontiac facility to its Clarkston campus and to develop the Pontiac campus to a more efficient health care delivery location and an educational center will be a boost to the local economies of both Pontiac and Clarkston;

AND

WHEREAS: The expansion of the Clarkston campus will provide innovative services and meet the needs of an expanding population of consumers. It will improve the health care of citizens in the Clarkston area and will lead to innovations in health care that will be of value to all the citizens of Michigan

NOW, THEREFORE, BE IT RESOLVED that the Oakland County Association Township Supervisors provides its endorsement and support for McLaren's plans to improve access to lifesaving health care services, create new jobs, improve health education and primary care services for the communities in Oakland County.

PASSED AND APPROVED this day August 20, 2012.

SIGNED: Thomas R Rzeznik, Commerce Twp., Supervisor
(*name and title of signatory*)

CERTIFICATION:
I, the undersigned (*title*), do hereby certify that the full (*board, assembly, or council*) composed of (*number of*) members, of whom (*number*) were present on (*date of approval*), adopt the above resolution by an affirmative vote of (*number*) members.

SIGNED: Thomas R Rzeznik President
(*name and title of signatory*)

Greater Pontiac Community Coalition
G P C C
Established in 1994
501-C3

143 Oneida Road - Pontiac, MI 48341
(248) 335-8740
(248) 335-7330 Fax

Angela Griffin, Board Chair
Rev. Douglas P. Jones, President

April 23, 2012

McLaren Oakland
Attn: Mr. Clarence Sevillian,
President/CEO
50 N. Perry St.
Pontiac, MI 48342

Dear Mr. Sevillian,

I trust this letter finds all is well with you and the wonderful people at McLaren Oakland!

On March 27, 2012 you made a presentation to the "Committee of Fifty" on the status, contribution, goal, service, and vision for the hospital. We were very impressed with your commitment to the Greater Pontiac Community, its people and its growth.

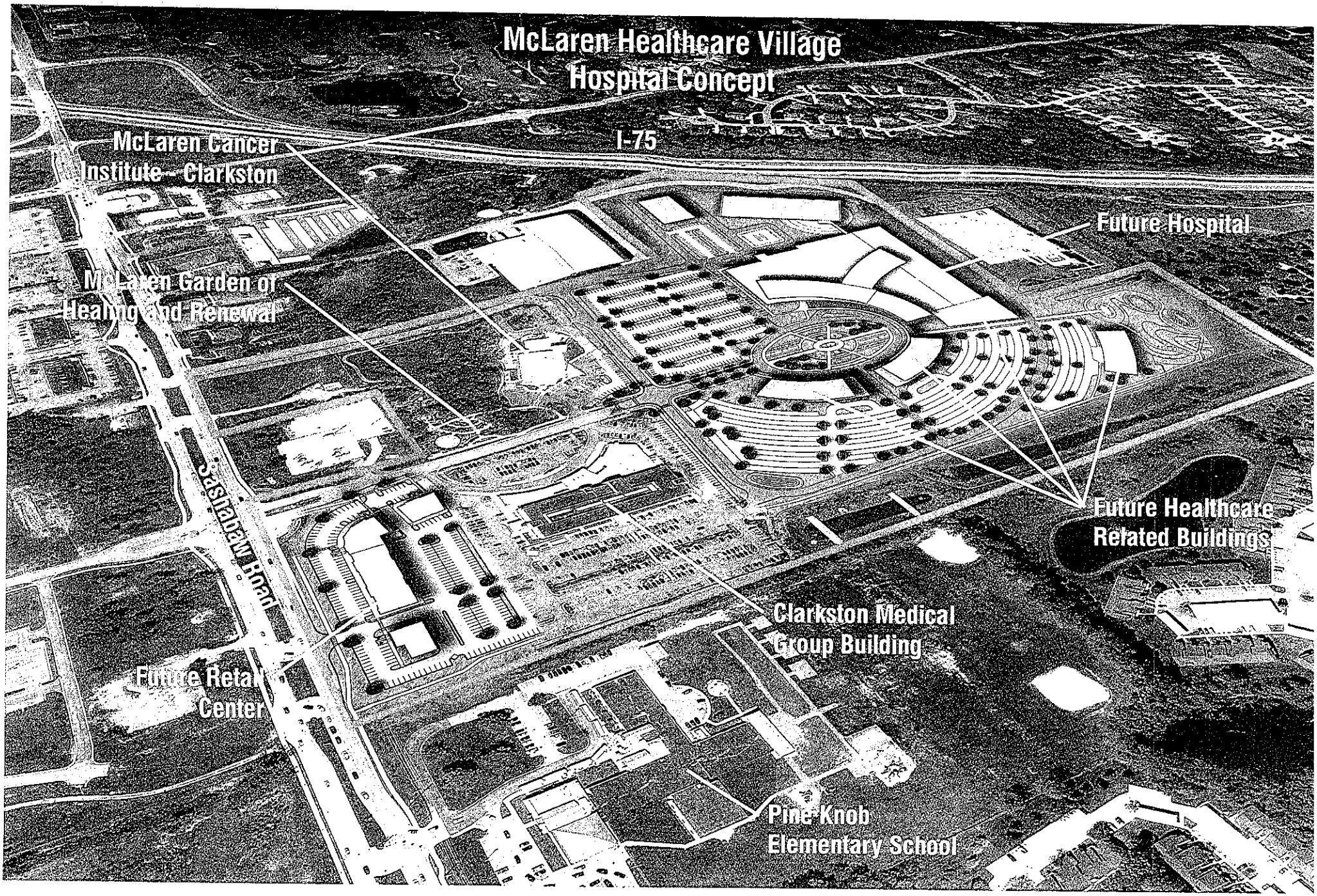
Having heard your presentation and the options of transferring beds to your parent location which will aide in the vision for the Clarkston location a vote was motioned, seconded and held in support of that move by your leadership and board.

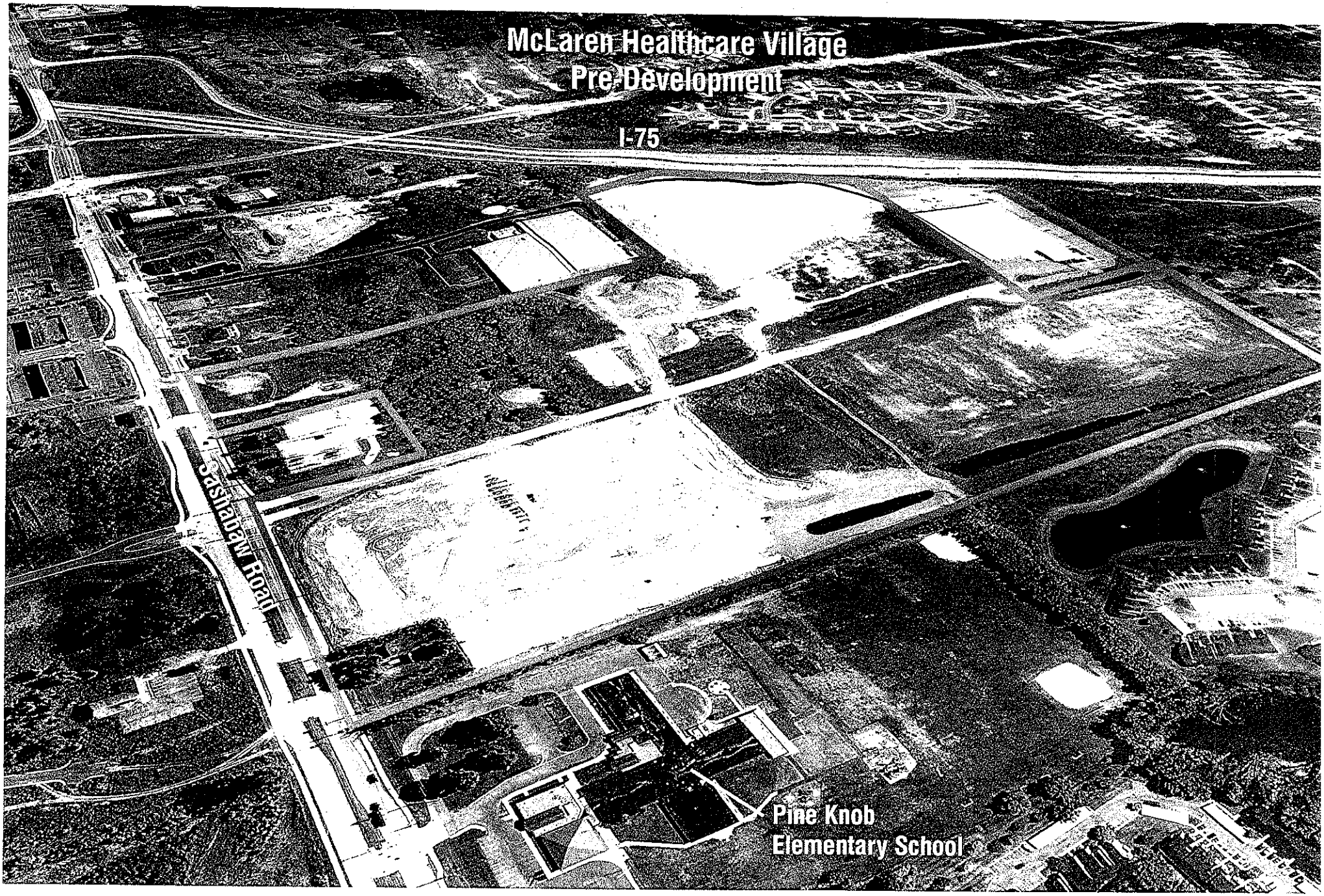
We the "Committee of Fifty" wholly endorse, support and encourage this effort on the part of McLaren. We offer our assistance in whatever way to make this happen.

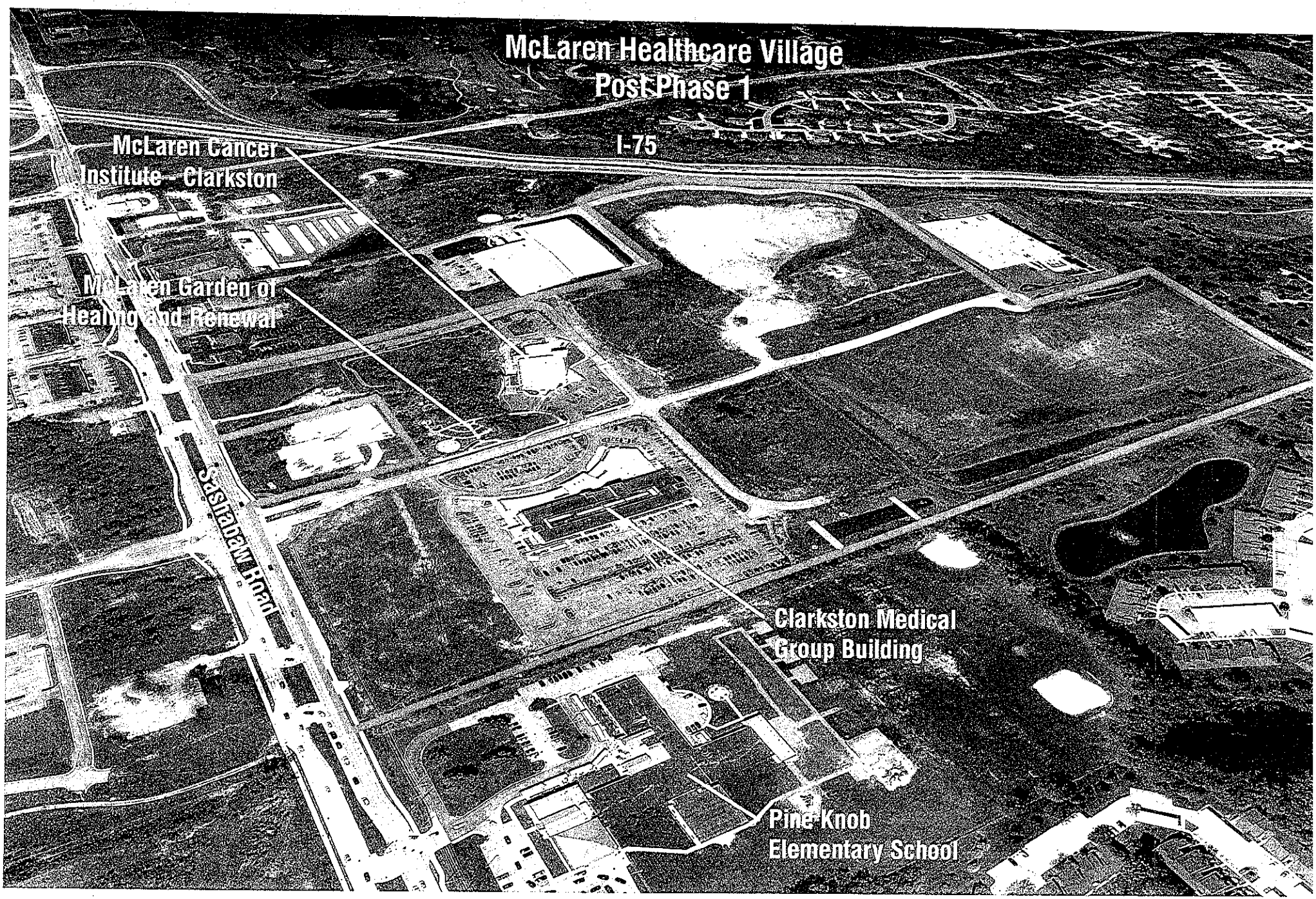
Good luck and the best to you with your plans.

Sincerely,

Rev. Douglas P. Jones
Cc: Philip Incarnati, President/CEO


McLaren Healthcare Village
Hospital Concept
I-75
McLaren Cancer
Institute – Clarkston
McLaren Garden of
Healing and Renewal
Future Hospital
Future Healthcare
Related Buildings
Clarkston Medical
Group Building
Pine Knob
Elementary School


McLaren Healthcare Village
Pre-Development
I-75
Sashabaw Road
Pine Knob
Elementary School


McLaren Healthcare Village
Post Phase 1
I-75
McLaren Cancer
Institute - Clarkston
McLaren Garden of
Healing and Renewal
Sashabaw Road
Clarkston Medical
Group Building
Pine Knob
Elementary School


Future McLaren Hospital